HMO
CERTIFICATE OF COVERAGE

INTRODUCTION

This Certificate summarizes the provisions of the Contract, but does not constitute the agreement between ADVANTAGE Health Solutions (ADVANTAGE) and the Group. We have made a reasonable effort to have this Certificate represent the intent of the Contract. However, the Contract stands alone and is not added to, or changed in any way, by this Certificate. In the event of any conflict between the Contract and this and the Group in the Group's offices during regular business hours.
Please read this entire Certificate so that You will understand Your Coverage and Your responsibilities under this plan.
This Certificate replaces and supersedes any Certificate of Coverage that We may have previously issued.

You will receive and Identification Care (ID Card) for You and each Eligible Dependent. This ID card will include name, identification number, the name of the Primary Care Physician. Carry your ID Card at all times. Present it whenever Medically Necessary services or supplies are needed.
If you ID Card is lost or stolen, contact the Member Services Department at:

- (317) 573-6228 or 1-800-553-8933
- TDD: 1-800-743-3333 (hearing impaired)

Our address is : ADVANTAGE Health Solutions, Inc.
9490 Priority Way, West Drive
Indianapolis, Indiana 46240

TABLE OF CONTENTS

ARTICLE I - DEFINITIONS

Unless otherwise indicated, terms identified with initial capital letters have the meanings defined below or explained elsewhere in this Certificate.

The words “he”, “his”, and “him” are inclusive of the terms “she”, “hers”, and “her”.

1.1 ADVANTAGE HEALTH SOLUTIONS, Inc. or ADVANTAGE means corporation authorized to do business in Indiana, licensed under the Indiana Health Maintenance Organization law, which has a contract with GROUP to arrange for health care services for Members as set for herein.

1.2 ALLOWED AMOUNT means the maximum allowable reimbursement for a Covered Service. The Allowed Amount is based upon the lesser of:

1. fee arrangements between ADVANTAGE (or an organization designated by ADVANTAGE) and the Provider; or
2. the billed charge.

When Covered Services are provided by a Participating Provider, the Member is not responsible for charges above the Allowed Amount. When Covered Services are provided by a non-Participating Provider, the Member may be responsible for charges above the Allowed Amount.

1.3 ANNUAL BENEFIT MAXIMUM means a maximum number of visits, days or sessions that will be provided per Covered Service, per Member, and per Calendar Year.

1.4 AT HOME POST DELIVERY CARE means health care services provided to a woman at her residence, including, but not limited to:

1. parent education,
2. assistance and training in breast or bottle feeding; and
3. any maternal and neonatal tests routinely performed during the usual course of Inpatient care for the woman or her newborn child, including collection of an adequate sample for the hereditary and metabolic newborn screening.

Services may be provided by:

1. a physician;
2. a Registered Nurse; or
3. an advanced practice nurse whose scope of practice includes providing postpartum care in the area of maternal and child health care.

The At Home Post Delivery Care visit must be provided within 48 hours after the mother and newborn child are discharged from the Hospital. At the mother’s discretion, the visit may occur in the Provider’s office.

1.5 BEHAVIORAL HEALTH NETWORK means a contracted network of mental health or substance abuse providers affiliated with a Member’s assigned PCP. The network is responsible for arranging the provision of behavioral health services, coordination of care, and case management.

1.6 CERTIFICATE OF COVERAGE means the document given to every Subscriber, which summarizes the provisions, definitions and benefits found in this Contract.

1.7 COINSURANCE means the percentage of the Allowed Amount that is the Member’s responsibility.

1.8 CONTRACTING HOSPITAL means a duly licensed acute care Hospital licensed by the Department of Health and Social Services, State of Indiana, and certified for participation under Medicare or Medicaid (Titles XVIII or XIX of the Social Security Act) and who entered into an express or implied contract with ADVANTAGE to Provide Covered hospital Services to Members.

1.9 CONTRACTING PHARMACY means a pharmacy or organization of pharmacies licensed by the State and which has entered into an express or implied contract with ADVANTAGE or which has a contract with another ADVANTAGE Pharmacy to provide services to ADVANTAGE Members.

1.10 CONTRACTING PHYSICIAN means a physician who is licensed to practice medicine in the jurisdiction where services are rendered and who is employed by or under an express or implied contract with a

Physician Network as defined in Section 1.37 or; in rare cases, who is under contract directly with ADVANTAGE.

1.11 CONTRACTING PROVIDER means a licensed physician and other health care professionals, Hospitals, Skilled Nursing Facilities (hereinafter referred to as SNF's), home health care agencies or other providers of health care services who have entered into an express or implied contract with ADVANTAGE, a Physician Network,, or a Contracting Hospital to provide services to Members.

1.12 COORDINATION OF BENEFITS means an attempt by an ADVANTAGE Provider and/or ADVANTAGE to recover the cost of care provided to a Member of a third party. The third party may be another insurer, such as automobile, home, business, and/or renter, service plan, government third party payor, or other organization, which also provides coverage for the Member's health care needs. Coordination of Benefits is subject to any limitations imposed by this Contract or another applicable policy preventing such recovery.

1.13 COPAYMENT means charges which may be collected directly by the ADVANTAGE Provider from a Member as additional payments for services rendered under the Certificate of Coverage. The Copayments are set dollar amounts and are not based on a percentage of the billed or allowed amounts. The Copayments for Covered Services are set forth in the Application at the front of this Contract.

1.14 COSMETIC means to involve physical appearance, but does not correct or materially improve a physiological function and not medically necessary.

1.15 COVERED SERVICES means those Medically Necessary health care services and supplies as set forth in the Schedule of Benefits. Services which are not Medically Necessary shall not be deemed Covered Services for purposes of this Contract, except as otherwise provided herein.

1.16 CRISIS INTERVENTION means emergency or urgently needed medical or mental health services, including assessment, diagnosis and treatment, provided during an acute phase of illness, sickness or injury to stabilize the immediate condition.

1.17 CUSTODIAL CARE means care furnished for the purpose of meeting personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered under this Contract.

1.18 ELIGIBLE DEPENDENT or DEPENDENT shall have the same meaning as set forth in AGREEMENT FOR PREPAID HEALTH MAINTENANCE ORGANIZATION AND ADMINISTRATIVE SERVICES BETWEEN STATE OF INDIANA AND ADVANTAGE HEALTH SOLUTIONS, INC., Article V., Section A.. To be an Eligible Dependent, a person must reside within ADVANTAGE'S Service Area.

Guardianship of a child means any unmarried child: under nineteen (19) years of age; for whom the Subscriber or the Subscriber's legal Spouse has assumed the legal obligation for total or partial support; and for whom either a final decree of guardianship has been entered, or a petition for guardianship has been duly filed with the intent to obtain a final decree of guardianship.

1.19 EMERGENCY SERVICES means services provided due to a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to :

1. place an individual's health in serious jeopardy
2. result in serious impairment to the individual's bodily functions; or
3. result in serious dysfunction of a body organ or part of the individual.

1.20 GROUP SERVICE AGREEMENT or Subscriber GROUP Contract or Contract means the contract agreed to by and between ADVANTAGE and the respective Group, which expresses the rights and obligations of the parties thereto. It also describes the costs, procedures, benefits, conditions, limitations, exclusions, and other obligations to which Members are subject under ADVANTAGE's health maintenance organization.

1.20 HEALTH PROFESSIONAL means a professional engaged in the delivery of health services who is licensed, where required, under the laws of the jurisdiction where services are delivered and operating within the scope of his/her license.

1.21 HOME HEALTH SERVICES means health services delivered in Member's home setting and provided by an organization licensed by the State and operating with the scope of its license.

1.22 HOSPITAL means an acute care Hospital duly licensed in the jurisdiction where services are rendered.

1.23 ILLNESS means a sickness or disease and all related conditions and recurrences. The term Illness includes pregnancy and all related conditions.

1.24 INDIVIDUAL CONVERSION CONTRACT means the contract, which may be entered into by and between ADVANTAGE and the respective Subscriber and dependents, which sets forth the terms under which the Member and Eligible Dependents may be allowed to convert to individual coverage after termination of coverage under the Contract. The Individual Conversion contract expresses the contractual rights and obligations of the parties thereto, and which describes the costs, procedures, benefits, conditions, limitation, exclusions, and other obligations to which Members are subject under ADVANTAGE's health maintenance organization.

1.25 INJURY means an accident to the body that requires medical or surgical treatment.

1.26 INPATIENT means confinement as a bed-patient for 24 hours or longer in a Hospital, Skilled Nursing Facility, or Hospice Facility.

1.27 INVESTIGATIONAL means:

1. Any intervention (treatment, procedure, facility, equipment, drug devise, service, or supply):
   a. not generally and widely accepted in the practice of medicine in the U.S. ; and
   b. whose effectiveness is not documented in peer-reviewed articles in medical journals published in the U.S. For interventions to be considered effective, journal articles should indicate that the intervention is more effective than other available, or, if not more effective, is safer or less costly.
2. Interventions that are considered experimental or investigational by:
   a. the U.S. Department of Health and Human Services;
   b. the National Institute of Health; or
   c. any of their subsidiary agencies
3. Drugs or medical devises that do not have Federal Drug Administration (FDA) marketing approval or other governmental agency approval as required by law.
4. Medical Devices that have FDA approval under 21 CFR 807.81, but whose effectiveness for the proposed use has not been documented in peer-reviewed articles in medical journals published in the U.S. For devices of this type to be considered effective, such articles should indicate that the device is more effective than other devices available for the proposed use, or, if not more effective, is safer or less costly.

1.28 LATE ENROLLEE means a Subscriber or Eligible Dependent who did not request enrollment in this Plan:

a. During the initial enrollment period in which he/she was first entitled to enroll; or
b. During any Special Enrollment period, as provided in this Contract.

The term "Late Enrollee" does not include:

a. A Subscriber or Eligible Dependent who:
   i. Was covered under another health insurance plan or had other health insurance coverage at the time coverage was previously offered to him/her; and
   ii. Requests enrollment within 31 days after losing that other coverage due to:
      a. Exhausting his/her COBRA coverage;
      b. Loss of eligibility for the other coverage, including as a result of legal separation, divorce, death, termination of employment, or reduction in work hours;
      c. Termination of employer contributions toward other coverage.
b. A Subscriber who:
   i. is employed by an employer that offers multiple health insurance plans; and
   ii. elects a different plan during an open enrollment period.

c. An Eligible Person and his Spouse, minor child, or Eligible Dependent child, when:
   i. a court orders that health insurance coverage for the Spouse, minor child, or Eligible Dependent child be provided under this Plan; and
   ii. enrollment is requested within 31 days after the order was issued.

d. A child under age 18, when a court orders the Eligible Person or an Eligible Dependent to provide health insurance coverage for the child.

1.29 MEDICALLY NECESSARY means medical or surgical treatment which a Member requires, as determined by one or more Contracting Physicians, which is: 1) in conformity with the professional and technical standards adopted by the Quality Improvement Committee and Utilization Review Committee of the Physician Network, the Medical Group and ADVANTAGE; and 2) in accordance with accepted medical and surgical practices and standards prevailing at the time of treatment. Services shall not be deemed Medically Necessary if serves are rendered primarily for the convenience of the Member or provider.

1.30 MEMBER means an enrollee in ADVANTAGE Health Solutions, and in this Document, usually refers to the Subscriber or the Subscriber's enrolled Eligible Dependent.

1.31 OPEN ENROLLMENT PERIOD means a period of time set by the GROUP during which ADVANTAGE may seek to enroll new Members. During Open Enrollment, Eligible Employees and their Eligible Dependents may transfer to ADVANTAGE or to another health care plan or insurer offered by the GROUP without providing proof of insurability, or transfer to another Physician Network within ADVANTAGE. During Open Enrollment, ADVANTAGE must be given access to the GROUP's employees on the same terms as other health plans and insurers.

1.32 OUTPATIENT means medical services not provided in, an Inpatient care setting.

1.33 OUT OF POCKET MAXIMUM means the maximum Coinsurance amount for Covered Services per member and per family per calendar year.

1.34 PCP or PRIMARY CARE PHYSICIAN means the Contracting Physician selected by a Member to provide, supervise, and/or coordinate the provision of Covered Services to Members. All services not provided by PCP must be obtained through Proper Referral from PCP. Primary Care Physicians may include Family or General Physicians, Internists, Pediatricians and OB-GYN's.

1.35 PHYSICIAN means a duly licensed practitioner of the medical arts. The Physician must hold an unlimited license to practice medicine or osteopathy in the State of Indiana and must be practicing within the scope of that license.

1.36 POLICY MAXIMUM means the total amount payable for all covered benefits a Member receives for as long as he/she remains a Member. If there is a lapse in a Member's coverage, the Policy Maximum applies to all benefits received before or after the lapse.

1.37 PHYSICIAN NETWORK or PN or Medical Group means a Physician Hospital Organization, individual practice association, or medical group that has entered into Provider Services Agreement with ADVANTAGE to provide Covered Services to Members. A Physician Network has as its primary purpose the delivery, or the arrangement for the delivery, of Covered Services. A Physician Network is an entity which has entered into written service or employment agreements or other arrangement with health care professionals, the majority of whom are licensed to practice medicine or osteopathy.

1.38 PROPER REFERRAL means the process set forth in Section 3.2 or in the Certificate of Coverage, upon which a Contracting Primary Care Physician directs a Member to seek or obtain Covered Services from another Health Professional or inpatient facility. A Proper Referral must comply with ADVANTAGE policies and/or approval process of the PN.

1.39 PROVIDER means any Hospital, Skilled Nursing Facility, individual, organization, or agency who is licensed to provide professional services within the scope of that license or certification.

1.40 QUALITY IMPROVEMENT ("QI") COMMTTEE means the committee of physicians and other Health Professionals selected and approved by the Physician Network and/or medical group to promulgate and maintain professional standards.

1.41 SECOND OPINION means a medical or surgical opinion that is provided by a Physician, other than the Member's PCP, to reevaluate the Member's condition. The Second Opinion is made with prior authorization from ADVANTAGE.

1.42 SERVICE AREA means the geographical area within thirty (30) air miles of theMember's selected Primary Care Physician.

1.43 SKILLED MEDICAL SERVICES are those services, which under the State law must be provided by a licensed medical professional.

1.44 SKILLED NURSING FACILITY or SNF means an institution, or a distinct part of an institution, which:

1. is duly licensed in the state of Indiana;
2. is regularly engaged in providing 24-hour Skilled Care under the regular supervision of a Physician and the direct supervision of a Registered Nurse;
3. maintains a daily record on each patient; and
4. provides each patient with active treatment of an Illness or Injury, or related rehabilitation, in accordance with existing standards of medical practice for that condition.

A skilled Nursing Facility does not include any institution or portion of any institution that is primarily for rest, the aged, non-Skilled Care, or care of mental diseases or substance abuse.

1.45 SPECIAL ENROLLMENT PERIOD shall mean that period beginning the first day in which an eligible employee or eligible dependent, covered under another group health plan, loses that group coverage and subsequently requests coverage under ADVANTAGE within thirty-one (31) days from the loss of he other group coverage.

1.46 SPECIALTY CARE PHYSICIAN means a Physician:

1. who has an identified specialty other than a family practice, internal medicine, or pediatrics; and
2. who is not acting in the role of a PCP to the Member at the time services are provided.

1.47 SUBSCRIBER means the individual who resides and/or works in the geographic area in which ADVANTAGE is licensed, who meets the eligibility requirements of the GROUP, who has submitted a Application for ADVANTAGE membership, and for whom premiums have been paid.

1.48 SUBSCRIBER GROUP OR GROUP means the organization or firm contracting with ADVANTAGE to arrange to provide health care services for its Eligible Employees and their Dependents.

1.49 TERMINALLY ILL OR TERMINAL ILLNESS means a condition for which a Physician has given a prognosis that a Member has six months or less to live.

1.50 URGENT CARE CENTER means a medical facility operating within any required license or certification, where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive Urgent Care Services.

1.51 URGENTLY NEEDED SERVICES or URGENT CARE shall mean an instance when Member needs Covered Services urgently: (a) to prevent serious deterioration of health; (b) resulting from an unforeseen illness or injury; (c) while outside of the Service Area; (d) for which treatment cannot be delayed until the enrollee returns to the Service Area without the member's condition growing much worse.

1.52 USUAL, CUSTOMARY AND REASONABLE COSTS ("UCR") means the usual fee charged by the participating providers to Members for the same service, which the Physician Network has determined is reasonable based on the fee schedule for similar providers for the same services similar circumstances and in the specific geographic area where the services were provided.

1.53 UTILIZATION MANAGEMENT ("UM") COMMITTEE means the committee of physicians and other Health Professionals selected and approved by ADVANTAGE or the Physician Network which authorizes and performs prospective, concurrent, and retrospective review of health services provided to Members.

1.54 WOMAN AT RISK means a woman who meets at least one of the following descriptions: a woman who has personal history of breast cancer; a woman who has a personal history of breast disease that was proven

benign by biopsy; a woman whose mother, sister, or daughter has had breast cancer; or a woman who is at least 30 years of age and has not given birth.

ARTICLE II – ELIGIBILITY, ENROLLMENT, COVERAGE

THE ENROLLMENT PROCESS
To enroll in this Plan, You and Your Eligible Dependents must complete all steps of the Enrollment Process. If you do not select a PCP for yourself and/or Your Eligible Dependents, We will select one.

Upon completion of the Enrollment Process, We will issue an Identification Card and a certificate summarizing the Contract to the Subscriber or to the Group. If We issue the ID Cards and certificates to the Group, the Group agrees to distribute the cards and certificates to each Subscriber.

You must enroll Yourself and Your Eligible Dependents during an Open Enrollment Period.

EFFECTIVE DATE OF COVERAGE
Your Effective Date of Coverage is determined by the Group, as defined in Article V, Section C of the Mother Agreement. Coverage begins at 12:01a.m. on the Effective Date of Coverage.

SPECIAL ENROLLMENT EXCEPTIONS

1. A child born to You or to Your Eligible Dependent, or adopted by You within thirty-one (31) days of birth, is automatically entitled to receive Covered Services for the first thirty-one (31) days from date of birth. If Newborn is not a child born to You or Your Eligible Spouse, or is not covered under the provision for adopted children or guardianship as provided in Article V of the Mother Agreement, then newborn shall not be eligible for coverage beyond the thirty-first (31) day. Within thirty-one (31) days of birth, Your newborn must be an enrolled ADVANTAGE member for coverage to continue beyond the first thirty-one days (31). Also the premium, if any, must be paid on behalf of the newborn for coverage to continue beyond the first thirty-one (31) days. If the newborn is not enrolled as a Member with Us within thirty-one (31) days of the date of birth the child will be declared ineligible for Covered Services after thirty-one (31) days from date of birth. In that case, You, not ADVANTAGE, will be responsible for payment of services, which were provided to the child after the thirty-first (31) day. Nor will We arrange or provide for the child's care after the thirty-first (31) day in that case.
2. Adopted children. Adopted children are eligible for coverage as of the earlier date of placement with You and/or Your Spouse. Application must be made and payment received by Us within thirty-one (31) days of either the placement of date of adoption for coverage to continue beyond the first thirty-one (31) days. If Your adopted child is not enrolled within the thirty-one (31) days, then the rules applicable to Late Enrollees, below, apply.
3. Guardianship. Children under Your or Your Spouse's guardianship are eligible for coverage as of the earlier placement with Your or Your Spouse, or the date of guardianship under Your or Your Spouse. Application must be made and payment received by Us within thirty-one (31) days of either the placement or date of the legal guardianship for coverage to continue beyond the first thirty-one days.
4. The provisions of this Contract will apply equally to You and to Your Eligible Dependents, when family coverage is chosen, except as described below.
    - All benefits and privileges made available to You shall be available to Your Eligible Dependents, except for: eligible Dependent children who marry may not enroll their Spouses and cease to be eligible for coverage as an Eligible Dependent.
5. Children who reach the Limiting Age for Coverage. Coverage for Your dependent child will end on the last day of the calendar year without notice when Your dependent reaches the limiting age of 19. The limiting age is also set forth on the Application for Group Service Agreement. But, if Your dependent is: a full-time student at an accredited school of higher learning or trade school; and still dependent upon You for support, a different limiting age applies. In that case coverage may be extended to the end of the calendar year in which the dependent turns 23. We may request proof of support and/or proof of full time attendance at school.
6. Disabled Children. Coverage may be extended beyond the limiting age where Your enrolled dependent child is medically certified as being incapable of self-sustaining employment by reason of mental retardation or physical handicap that began before the limiting age (described in the Application) was reached; and primarily dependent upon You for support and maintenance. Proof of such incapacity and support must be given to Us within thirty (30) days of Our request. We may require such proof from time to time, but not more frequently than once a year. The proof must include a statement by a licensed

psychologist, psychiatrist, or other physician and proof of continued dependency, such as most recent income tax forms.

7. Service Area. With the exception of a full-time student as described herein, if You have Your permanent residence outside the Service Area, You and Your Eligible Dependents will be ineligible to join or continue their coverage under the Group Service Agreement, unless You select a new Primary Care Physician within thirty (30) air miles of Your new residence. If there is no Contracting Primary Care Physician available within thirty (30) air miles of Your new residence, then You should contact Your GROUP to determine if other coverage is available. You must notify Us of any move or extended absence may result in Your having to pay for services obtained outside of the Service Area. Because Our Service Area may change from time to time, You should contact Us to determine if Your new home address is within our Service Area.
8. Whenever a child of a non-custodial parent has coverage, the custodial parent may receive information that is necessary for the child to obtain Covered Services. However, We shall not be obligated to provide such information to the custodial parent unless We are provided with the correct address. The custodial parent will be entitled to submit claims from Providers for Covered Services.
9. Certificates of Creditable Coverage. If Your coverage with Us terminates, You may be asked by the replacement carrier for a "Certificate of Creditable Coverage". The certificate will help the replacement carrier assess to what extent its preexisting condition exclusions apply. If You have not been without coverage for more than sixty-three (63) days, the replacement carrier must reduce its preexisting condition time period by total of any periods of creditable coverage (as defined in Federal law) You may have had under prior plans. We will provide You with a certificate setting forth the: period that You were covered under Our plan; the length of waiting period under the plan (if any). We will make these certificates available when: You stop being eligible for the plan; You reach the end of COBRA coverage; and/or upon Your request, but only if the request is made within twenty-four (24) months after coverage ends. We will also provide to the succeeding carrier, upon request of the carrier, a certificate explaining Your benefits under Our plan. We reserve the right to charge a fee to the other carrier for that certificate.
10. Court-Ordered Guardianship: A court grants guardianship of an Eligible Dependent to you. The date of status change is the date the court order is issued.
11. Special Enrollment Periods.
    (a) the special enrollment period for loss of other coverage is available to individuals who have been covered under another health plan when We were first offered to the individual, the individual declined coverage in writing due to the other coverage, and coverage has now been lost. If You have not previously enrolled, You can enroll with Us under the special enrollment period if it is the employee who loses other coverage. Your dependent can be enrolled under the special enrollment period for loss of coverage if it is the dependent who loses other coverage and You are already enrolled. In addition, both You and Your dependent can be enrolled together under the specail enrollment period if either You or Your dependent loses other coverage. If the other coverage is Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the special enrollment can only be requested after exhausting COBRA continuation coverage. Special Enrollment can only be requested after losing eligibility of the other coverage or after cessation of employer contributions for the other coverage. In each case, You have sixty-three (63) days to request special enrollment.
    (b) Special enrollment period also occurs if You have a dependent by birth, marriage, adoption or placement for adoption. If You are an ADVANTAGE Subscriber, Your newly acquired Spouse may become enrolled with Us by the first of the following month. If You are not an ADVANTAGE Subscriber, Your newly acquired Spouse can be enrolled together with You when You marry or when Your child is born, adopted or placed for adoption. A child who becomes Your dependent as a result of marriage, birth, adoption or placement for adoption can be enrolled if You enroll at the same time. The election to enroll newly acquired depends under special enrollment must be made within thirty-one (31) days following the birth, marriage, adoption, or placement for adoption.
    (c) Court-Ordered Coverage: A court or administrative agency of competent jurisdiction orders You or Your Eligible Dependent to provide health coverage for a child under age 18. The child may be enrolled by
        a. his custodial parent;
        b. his non-custodial parent;
        c. the office of Medicaid policy and planning; or
        d. a Title IV-D agency.

        The date of status change is the date the order is issued.
        NOTES:

a. Enrollment is allowed any time after the order is issued. The amount the Subscriber must contribute toward the Enrollment Fee may increase when Your new Eligible Dependent is added.

OTHER RULES OF ENROLLMENT

If both parents are Subscribers, only one parent can enroll the child as an Eligible Dependent. No one will be refused enrollment or re-enrollment because of:

1. health status;
2. medical condition;
3. claims experience
4. receipt of health care;
5. medical history;
6. genetic information;
7. evidence of insurability (including conditions arising out of acts of violence; or
8. disability

A person who previously had coverage voided under this Plan or another ADVANTAGE plan because of:

1. fraud;
2. misrepresentation;
3. misusing an ID Care; or
4. failure to make payment, unless payment has since been made in full;

may not enroll in this Plan.

CONTINUATION OF COVERAGE FOR CERTAIN SUBSCRIBERS AND FAMILY DEPENDENTS (COBRA COVERAGE)

A federal law referred to as COBRA, which stands for the Consolidated Omnibus Budget Reconciliation Act of 1986, and any amendments thereto, provides You the right to elect to continue Coverage under a group-established benefit plan under certain circumstances. This law applies to employers with 20 or more regularly scheduled full time employees as of the last six months of the past Calendar Year. If the Group is a multiple employer group, the Group may be subject to COBRA, even if not all of the employers would be subject to COBRA when considered individually.

Obtaining COBRA Coverage:

In order to obtain COBRA Coverage under the Contract, the Group must notify all Members of their right to continued group coverage as required by, and in accordance with, federal law; notify Us as soon as possible when You elect to continue Coverage. This notice must also state the date Your COBRA Coverage becomes effective; and collect and forward all applicable Enrollment Fees to Us on a timely basis.

In order to obtain COBRA Coverage, the Group must provide all information requested by Us regarding COBRA continues when the Group application is made, or in the case of an acquisition or merger, prior to the effective date of the acquisition or merger.

CONVERSION TO INDIVIDUAL COVERAGE

You will be entitled to an individual conversion policy, without evidence or insurability, if:

1. You were continuously covered under the Contract for a least 90 days;
2. You request the conversion policy from us within 30 days of loss of Coverage; and
3. You cease to be covered under the Group Service Agreement as a result of:
   a. leaving the Group or a reduction in his hours of employment;
   b. the Subscriber's death or termination of marriage; or
   c. ceasing to meet the definition of Dependent Child.

If eligible for COBRA coverage, You must exhaust COBRA Coverage before requesting a conversion policy. The conversion policy will be issued without regard to health status or requirements for health care services. If You elect to exercise this conversion privilege, the conversion shall be effective retroactive to the date and time coverage terminated under the Contract, subject to the payment of any applicable premium due.

You must pay ADVANTAGE, less any Copayment and Coinsurance, for the reasonable value of health services or benefits provided under the Contract during the 30-day election period, if the conversion privilege is not exercised.

EXCEPTIONS TO CONTINUATION OF COVERAGE AND CONVERSION
Neither You nor Your enrolled Eligible Dependents will be eligible for Continuation of ADVANTAGE Coverage under COBRA or for conversion to an Individual Conversion Contract if any of the following circumstances apply:

- Coverage was terminated by Us or the GROUP
- You have moved out of the geographic area in which We are licensed to operate.

In the event that You are deemed ineligible for conversion, Your Enrolled dependents will also be deemed ineligible for conversion, unless otherwise required by law.

ARTICLE III – SELECTION OF PHYSICIAN; REFERRAL SERVICES; RELEASE OF MEDICAL RECORDS : OTHER RIGHTS AND DUTIES OF MEMBERS

SELECTION OF A PRIMARY CARE PHYSICIAN
You shall select a Primary Care Physician(s) to arrange physician and related services for You and Your Eligible Dependents. The Primary Care Physician(s) must be selected from the ADVANTAGE Provider Directory. You and Your Eligible Dependents must all reside within the Service Area of the Primary Care Physician(s) selected. You and all Your Eligible Dependents may select a different Primary Care Physician. The Physician Network will provide and/or arrange and pay for physician and related services needed by You. In return, the Physician Network is paid a capitation payment by Us and the applicable Copayments by You or Your Eligible Dependents.

We do not guarantee the continued participation of any Provider listed in the ADVANTAGE Provider Directory. Should We receive notice from a Contracting Physician that he/she wishes to terminate participation with Us, We will make good faith efforts to notify You at least thirty (30) days prior to the effective date of termination.

COORDINATION AND AUTHORIZATION OF CARE
Your Primary Care Physician (PCP) is responsible for referring You for appropriate, Medically Necessary, covered specialist, ancillary and/or inpatient care. These referrals must be authorized in advance by Your PCP through a Proper Referral. If You obtain such services without Proper Referral by Your PCP, the service will not be covered by Us, except in the case of Emergency Services. Some services, which may include, but are not necessarily limited to, specialty physician services, inpatient hospital services and outpatient surgeries also require the approval of the UM Committee before the PCP may make a Proper Referral. All Home Health Services must be authorized by the PCP and/or PN and/or Us.

You may already be receiving services when You enroll in Our Plan. You may also need to select a new PCP. If one or both of these circumstances occurs, You must contact the selected PCP to request approval for all health care services and treatments that You are receiving or that are currently in progress upon the effective date of enrollment.

PRIMARY CARE PHYSICIAN MUST PROVIDE OR ARRANGE COVERED SERVICES IN ORDER FOR THE SERVICE TO BE PAYABLE.
You are entitled to the services described in the Summary of Benefits, when such services are provided or properly arranged by a Primary Care Physician.

CONSENT TO RELEASE INFORMATION
If you completed an ADVANTAGE application for membership or a Routine Consent Form, You consent on behalf of Yourself and each of Your Eligible Dependents to permit Us to utilize your personal medical information for future, known or routine needs in the course of arranging for your health care and benefits. This may include: treatment; coordination of care; case management; disease management; quality assessment and measurement; accreditation; decisions about the payment of services; and, other normal business operations related to administering the health plan. Information may be transmitted to or from Us for the purpose of arranging for your health care and benefits. The consent may be revoked in writing at anytime.

HOW TO TRANSFER TO A DIFFERENT PCP
You and Your Eligible Dependents may request transfers to a different PCP prior to the next Open Enrollment one time without cause, and additional requests can be made for good cause. Examples of good cause to request a transfer include: breakdown in the physician-patient relationship which cannot be cured by transfer to a different physician within the Physician-Network; or You or Your Eligible Dependent moves outside of the Service Area served by the PCP. To change to a different PCP, You must complete all forms required by Us. Once ADVANTATGE receives the completed forms the change of PCP will be effective the first day of the following month.
We have the right to retroactively deny such transfer to the new PCP if We determine that You were under acute care at the time of request.

The Physician Network or PCP may also request a transfer of You and Your Eligible Dependents for good cause. We will respond to the Physician Network's or PCP's request within twenty (20) business days and will notify You of the decision. If We authorized the Physician Network's or PCP's request, the transfer shall become effective the first of the month following Our approval, unless otherwise authorized by Us.

In the case of a PCP's termination as a Participating Provider, no transfer will be approved if We believe that it would be medically appropriate to do so; and no transfer will be approved while You or Your Eligible Dependent(s) is in the middle of an acute phase of an illness or after the first three months of pregnancy.

You may file a grievance in accordance with the terms of this Certificate of Coverage if dissatisfied with Our decision. Whenever You initiate a transfer, You and Your Eligible Dependents will be responsible for paying the Primary Care Physician's UCR charges, if any, for copying any medical records which need to be transferred to the new Primary Care Physician or health plan. Due to contractual arrangements with PN or PCP, a transfer to a new PCP may result in a change of referral health care providers.

CASE MANAGEMENT SERVICES AND ALTERNATIVE CARE PLANS
In catastrophic and chronic high cost cases, We may:

- Assess Your continuing care needs; and
- Discuss the needs with Your Providers.

Through these discussion, We and the Providers may identify appropriate alternative means of medical care, which may be less costly. If the Providers, Us and You agree to an alternative care plan, Covered Services will be provided for the less costly alternative care, even though such alternatives are not specifically stated in this Certificate of Coverage.

Coverage for alternative care may be subject to the same Copayment requirements, if any, applicable to the medical care being replaced.

ARTICLE IV – MEMBERS' RIGHTS AND RESPONSIBILITIES

You, Your Physician and other health care providers are partners in Your health care. There are certain rights and responsibilities that are critical to this partnership. The manner in which You exercise these rights and responsibilities affects Our ability to make appropriate medical care available to all Our Members. You are entitled to these rights without regard to sex, race, culture, economic, educational or religious background.

YOU HAVE THE RIGHT…

- To select a Primary Care Physician (PCP) and to change Primary Care Physicians one time a year by contacting Member Services
- To have twenty-four (24) hour access to your PCP and if out of town, receive emergency care if necessary
- To receive prompt and appropriate treatment for physical and emotional disorders and disabilities in the least restrictive environment necessary for that treatment, and remain free from unnecessary or excessive medication
- To be informed by Your health care provider of information about Your diagnosis, treatment and prognosis in a manner that You can understand
- To participate in decisions involving Your medical care, You should receive enough information to enable You to make an informed decision before You receive any recommended treatment. The information should include the specific treatment or procedure, any medical alternatives and associated risks, regardless of cost or benefit coverage.
- To receive information on early hospital discharge and follow-up care, rehabilitation and living arrangements that are available once you are released from the hospital.
- To receive appropriate information so You may give an informed, voluntary consent to participate in any experimental research. (Experimental and investigational procedures are not covered in Our Plan.)
- To refuse treatment and to be informed of the probable consequences of Your action
- To have a guardian, next of kin or legally authorized person Your rights on Your behalf if Your medical condition causes You to be incapable of understanding or exercising Your rights.
- To know the cost of Your care and treatment and to receive an explanation of Your financial responsibility upon request
- To have Your health records kept confidential except when disclosure is required by law or permitted by You in writing. You have the right to review Your medical records with Your Primary Care Physician after adequate notice has been given
- To receive guidance and recommendations for additional medical care when coverage ends
- To be provided with information about Us, Our providers and Your rights and responsibilities

- To provide opinions about Us or the care provided by Your health care provider and to recommend changes in policies and services by contacting Member Services
- To be informed about Our grievance procedures
- To voice complaints or appeals about Us or the care you have received and to receive a response to complaints or appeals within a reasonable amount of time
- To be treated with respect and recognition of Your dignity and right to personal privacy
- To receive advice or assistance in a prompt, courteous and responsible manner
- To review the criteria utilized to make an adverse decision regarding any services requested but denied by our medical management department
- To continue receiving active treatment from Your provider even if the provider's network status changes (i.e. terminates from the network) until the current treatment period ends or up to 90 days, whichever is shorter

YOU HAVE THE RESPONSIBILITY…

- To keep scheduled appointments and give adequate notice of appointment delay or cancellation
- To be considerate of other patients and to be understanding and tolerant if any delays should occur
- To provide, to the extent possible, information that We and Our providers need in order to care for You
- To communicate openly with the provider and medical staff. If You have questions or disagree with the treatment plan, You have the responsibility to discuss Your concerns with the medical staff and make certain You understand the explanations and instructions
- To be honest, complete and accurate when providing information to the medical staff
- To follow the instructions and guidelines given to You by the medical staff and to consider the potential consequences if You do not comply
- To follow the plans and instructions for care that You have agreed upon by Your providers
- To understand what You are taking and whether follow-up care is needed
- To obtain a referral from Your PCP for any specialty care, before any specialist appointments are made
- To contact Your PCP for any necessary after hours care and to obtain a referral authorization number for those services
- To know how to access care in emergency, urgent and routine situations
- To express Your opinions, concerns, or complaints in a constructive manner to the appropriate personnel with Us or Your Provider Network
- To know the benefits and exclusions of Your coverage
- To contact Member Services for all questions and assistance
- To treat all Our and provider personnel in a courteous and respectful manner

ARTICLE V – ETHICAL AND RELIGIOUS DIRECTIVES

The Group acknowledges that We are an institution operated in accordance with the Ethical and Religious Directives for Catholic Health Care Services, as approved by the National Conference of Catholic Bishops. We shall not be required to provide, and no provision of the Contract shall be construed so as to require Us to provide, services that are inconsistent with the medical ethics or precepts of the Catholic Church.

ARTICLE VI – SCHEDULE OF BENEFITS

The health services listed in this section are covered under the Contract as follows. They must be: Medically Necessary; provided or arranged by an ADVANTAGE PCP or approved by Us or the PN as Emergency Medical Services; rendered to an eligible Member; and approved in accordance with the terms of the Contract. Health services are subject to the limitations and exclusions set forth in this Agreement. Any Copayment listed as a percentage of "charges" or "UCR" will be calculated on the basis of the provider's Usual Customary and Reasonable Charge (UCR) for the Covered Service, even if We ordinarily pays the provider on other than a UCR basis. Health care services must be provided by Participating Providers, unless otherwise authorized by ADVANTAGE or the PN. Health care services and supplies are Covered Services only if, and to the extent that, they are Medically Necessary, as determined by the Contracting Provider and Us or the PN.

Health services must be approved by the UM Committee or Us, if an admission, outpatient surgery or other high cost service is involved.

In the Subsections entitled "Copayments," below, We have in most cases listed the type of Copayment that applies, not the amount. See the Application for Contract (the "APPLICATION") at the front of this Certificate of Coverage for the actual Copayments that apply or call Our Member Services Department for the information.

1. TREATMENT OF ILLNESS OR INJURY

a. BENEFIT

i. Medically Necessary diagnostic services and treatment, including, but not limited to: primary care services; specialist services; and pediatric care for children. Includes:

ii. Physician office visits;

iii. Physician hospital visits;

iv. Physician home visits;

v. Allergy injections, serum, and testing

vi. Radiation therapy and chemotherapy

vii. Urgent Care visits and visits after hours

b. COPAYMENT

i. Physician office visit: The applicable Physician office visit Copayment applies to each visit.

ii. Physician hospital visits: No copayment applies.

iii. Physician home visits: The Physician home visit Copayment applies to each visit.

iv. Allergy injections and testing: No separate copayment applies; covered under the applicable physician copayment.

v. Serum: No separate copayment applies; covered under the applicable Physician copayment.

vi. Radiation and Chemotherapy: Applicable physician office copayment applies.

vii. Urgent Care visits and visits after hours: The Urgent Care visit Copayment applies to each visit.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

i. Physician office visits must be provided by Your Contracting PCP or, upon Proper Referral, the Physician to whom the PCP refers You ("the referral Physician")

ii. Physician hospital visits must be provided by a Contracting Hospital or, upon Referral, the Hospital to whom the PCP refers You ("the referral Hospital").

iii. Physician home visits must be provided by the Your PCP, or upon Proper Referral, a referral Physician. Services must be provided at Your home.

iv. Urgent Care visits and visits after hours must be provided by a Contracting Physician, an urgent care center or, with Proper Referral, the referral urgent care facility specified by the PCP.

v. Outpatient Physician Visit must be provided by Your PCP, Contracting Physician, with Proper Referral.

2. PERIODIC EXAMINATIONS

a. BENEFIT

General physical examinations including: history; laboratory (including, but not limited to pap smears and prostate specific antigen (PSA) tests); and x-ray services (including, but not limited to mammograms). Preventive care services include:

(i) Breast Cancer Screening

- One baseline breast cancer screening mammography for females age 35 through 39;
- One breast cancer screening mammography each year for
  - A female under age 40, who is a Woman at Risk; and
  - A female age 40 and over;
- Any additional mammography views that are required for proper evaluation; and
- Ultrasound services, if the treating physician determines they are needed

No PCP referral is required for services provided by a Contracting Provider.

(ii) Prostate Specific Antigen Tests (PSAT)

- One PSAT per calendar year for a male who is age 50 or older; or
- One PSAT 0per calendar year for a male who is under age 50 and at high risk for prostate cancer, according to the most recently published guidelines of the American Cancer Society

(iii) Routine Gynecological Services

- One routine gynecological exam and pap smear per calendar year
- No PCP referral is required if services are provided by a Contracting Provider

(iv) Well Child Care

- Clinical checks up to age two for the purpose of assessing physical status and detecting abnormalities, in the absence of symptoms
- Includes pediatric immunizations including, but not limited to: diphtheria, pertusis, small pox, measles, mumps, rubella, poliomyelitis, and tetanus.

b. COPAYMENT

The Physician office visit Copayment applies to each visit.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

Physical exams must be provided by Your PCP

3. HEALTH ASSESSMENT FOR PERSONS UNDER 18

a. BENEFIT

A health assessment for persons under 18 conducted by a nurse practitioner or physician and consisting of:
Vision Screening
Hearing Testing (one annual exam)
Immunizations
Developmental Testing
Lab Procedures
Physical Exam

b. COPAYMENT

The Physician office visit Copayment applies to each visit. Hearing Testing is covered at the applicable Physician copayment.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

Health assessments must be provided by the Your PCP.

4. NEWBORN EXAMINATIONS

a. BENEFIT

i. Newborn examinations, at the earliest feasible time, for the detection of:

- Phenylketonuria
- Hypothyroidism
- Hemoglobinopaths, including sickle cell anemia
- Galactosemia
- Maple Syrup urine disease
- Homocystinuria
- Inborn errors of metabolism that result in mental retardation and that are designated by the State Health Department
- Physiologic hearing screening examinations for detection of hearing impairments

If a parent of an infant objects in writing, for reasons pertaining to religious beliefs only, the infant is exempt from the examinations.

b. COPAYMENT

The Physician Office Visit Copayment listed in the Application at the front of the Certificate of Coverage.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

Services must be provided by Your PCP or by a Contracting Physician through a Proper Referral by the PCP.

5. LABORATORY AND X-RAY PROCEDURES

a. BENEFIT

Laboratory Tests, and X-ray examinations, CT Scans, Ultrasounds, MRI and Echocardiograms.

b. COPAYMENT

The Physician office visit Copayment applies if procedures are performed as part of physician office visit. Hospital Care—Inpatient Medical Hospital Copayment applies if You are admitted to a Hospital for the procedures.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

These services must be provided, with proper referral from Your PCP, by a Contracting Physician or other Contracting Provider or the referral provider specified by the PCP.

6. CARE FOR PREGNANCY

a. BENEFIT

Obstetrical care before, during, and after delivery, regardless of date of conception. The benefits include physician services, hospital services, and laboratory and x-ray services as Medically Necessary and appropriate.

After a normal, vaginal deliver, a woman and her newborn child may stay in the Hospital for a minimum of 48 hours. After a Cesarean section, a woman and her newborn child may stay for a minimum of 96 hours. A shorter length of stay is included in Covered Services, if:

i. the woman and attending physician agree that the woman or newborn child does not need further inpatient care;

ii. in the attending physician's opinion the newborn meets the criteria for medical stability under the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists Guidelines; and

iii. on "At Home Post Delivery Care" visit is provided.

b. COPAYMENT
   i. Prenatal and Postpartum Outpatient services: Physician Office Visit Copayment as specified on the application.
   ii. Inpatient Services: Hospital Care – Inpatient Medical Hospital Copayment applies to each admission.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
Services for pregnancy must provided by the PCP or, with Proper Referral from the PCP, by a Contracting Physician and/or Contracting Hospital.

7. UNPLANNED INTERRUPTION OF PREGNANCY (MISCARRIAGE)

a. BENEFIT
Miscarriages will be treated as any other illness, including, but not limited to Medically Necessary physicians' services, hospitalizations, X-ray, and laboratory services.

b. COPAYMENT
   i. Outpatient care: Physician office visit Copayment applies to each visit.
   ii. Inpatient care: Hospital care – Inpatient Medical Hospital Copayment applies to each admission.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
Services for miscarriages must be provided by Your PCP, or with Proper Referral by the PCP, by a Contracting Physician, Contracting Urgent Care Facility or Contracting Hospital.

8. IMMUNIZATIONS AND INOCULATIONS

a. BENEFITS
Immunizations and inoculations including, but not limited to diphtheria, pertusis, measles, mumps, rubella, poliomyelitis and tetanus (excluding those required for foreign travel only).

b. COPAYMENT
Same as Physician Office Visit Copayment

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
Immunizations and inoculations must be provided by the Your PCP.

9. MEDICAL SUPPLIES

a. BENEFIT
Casts, dressings, splints, and other devices used for reduction of fractures and dislocations. Other nondurable medical supplies are not covered, except of an integral part of a covered durable medical equipment set-up. See Subsection (22) below.

b. COPAYMENT
No Copayment

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
Medical supplies must be provided by a PCP, or with Proper Referral, the Contracting or referral Provider specified by the PCP.

10. HEARING TESTING

a. BENEFIT
Hearing test for all ages.

b. COPAYMENT
No separate Physician Office Visit copayment applies to each outpatient visit for hearing testing.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
Hearing tests are provided by Your PCP, or upon Proper Referral, another Contracting Physician or Contracting Provider facility.

11. EMERGENCY SERVICES

Emergency Services, are Covered Services and means services provided due to a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

(a) place an individual's health in serious jeopardy;
(b) result in serious impairment of the individual's bodily functions; or
(c) result in serious dysfunction of a bodily organ or part of the individual.

Care for Emergency Services may be obtained without prior authorization, or regard to a contractual relationship between the rendering provider and Us or a Physician Network. The rendering provider may not charge You except for the applicable Copayment specified on the Application to the Contract located at the front of the Contract and Certificate of Coverage.

To obtain Emergency Services in the Service Area or out of the Service Area, You must follow these steps:

1. How and where to receive Emergency Medical Services: If possible, You should call Your PCP or PN before obtaining Emergency Services. The PCP or on-call physician may be able to determine that an emergency does not exist and save You from incurring an unnecessary bill of non-covered services. If an emergency does exist, the PCP or PN may be able to advise You which Contracting Hospital is closet to You. If You obtain Emergency Services from a Contracting Hospital, You should not have to pay and seek a refund from Us or the PN. In that case, submit the claim to address listed on Your ID card with a request for a refund. Any refunds from Us or the PN will be less the applicable Copayment. We will only cover services which meet the definition of Emergency Services. Copayments for Emergency Services: The Copayment for Emergency Services is listed on the Application attached to the front of this Certificate of Coverage. There shall be no Emergency Services Copayment required if You are admitted to a hospital. However, the Hospital Care – Inpatient Medical Hospital Copayment will apply.

   Each authorized visit to a contracting or non-contracting emergency room or other provider of Emergency Services shall be paid at the Usual, Customary, Reasonable Charge ("UCR"), subject to applicable Copayments. If You seek Emergency Services from a non-contracting provider, We shall cover or reimburse expenses for the Emergency Services at a rate equal to the lesser of the following:

   a. The UCR in Our Service Area for health care services provided during the emergency; or
   b. An amount agreed to between Us and the non-contracting provider.

   Payment to the non-contracting provider or reimbursement to the Member is subject to the applicable Copayment for Emergency Services listed on the Application attached to the front of this Contract and Certificate of Coverage.

2. Notice of admission: You must notify PCP of emergency inpatient Hospital services as soon as possible, but in no event later than forty-eight (48) hours after admission, unless Your condition precludes notice. Notice to the PCP allows the PCP to be informed of the Your condition and, once You are stabilized, to coordinate Your care. If the Member is a minor, the parent or guardian must contact the PCP.

3. This benefit applies only to Emergency Services required by You before Your condition permits transfer to a Contracting facility or discharge.

To "stabilize" means to provide medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

   a. The discharge of the individual from an emergency department or other care setting where emergency services are provided to the individual;
   b. The transfer of the individual from an emergency department or other care setting where emergency services are provided to the individual to another health care facility;
   c. The transfer of the individual from a hospital emergency department or other hospital care setting where emergency services are provided to the individual to the hospital's inpatient setting.

Care and treatment provided to You once You are stabilized is not considered Emergency Services. Within the Our Service Area, all services following stabilization are subject to Proper Referral or must be arranged or provided by Your PCP. If the treating physician believes Your condition is stabilized and permits transfer to a Contracting Provider and You elect not to transfer, You will have to pay for any further services at the non-contracting provider.

12. HOSPITAL CARE

   a. BENEFIT

      The hospital services are covered when Medically Necessary, ordered or authorized by a Contracting PCP and approved by Us or the PN:

      i. Inpatient Medical and Surgical Services
      ii. Semi-private room and board; (Private room provided when Medically Necessary)
      iii. Intensive Care Unit/Coronary Care Unit;
      iv. Inpatient cardiac rehabilitation, limited to annual maximum of 90 days;
      v. Outpatient Surgery;
      vi. Other Medically Necessary Hospital Service, including but not limited to general nursing are, use of operating room or delivery suite, surgical and anesthesia services and supplies, ordinary casts,

splints and dressings, drugs and oxygen used in hospital, laboratory and x-ray examinations, electrocardiograms, and special duty nursing (when requested by a physician and certified as Medically Necessary).

b. COPAYMENT
   i. Inpatient Services; The Inpatient Medical Copayment applies to each admission.
   ii. The Outpatient Surgery Copayment applies to each procedure.
   iii. Emergency Services: Emergency Medical Services Copayment applies, except as noted above.
   iv. Other Hospital Services: No additional Copayment applies.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
   i. Inpatient services require Proper Referral by Your PCP and must be authorized by the UM Committee, except in the case of Emergency Services. Inpatient services must be provided by a Contracting Hospital unless services are not available there. In that case, the services may be provided in a referral Hospital, upon Proper Referral and authorization. If You are admitted to a non-contracting Hospital following Emergency Medical Services, that Hospital may provided Covered Services only until such time as You are well enough, in the opinion of the treating physician, to be transferred to a Contracting Hospital.
   ii. Hospital outpatient surgery services must be provided, with Proper Referral, by a Contracting Hospital or Contracting surgical center.
   iii. Emergency Services: See Section (12).
   iv. Other Hospital Services: Same as (13)(a), above.

13. SURGICAL PROCEDURES

a. BENEFIT

Medically Necessary professional services for surgical operations (major and minor), which are ordered or approved by a Contracting Physician:

- Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident occurring while a Member (if services begin within one year of the accident)
- Replacement of diseased tissue surgically removed while a Member
- Treatment of birth defect in a child who has been continuously covered as a Member since birth; or
- Breast reconstruction and prosthetic devices after a Medically Necessary mastectomy, including reconstructive surgery on both breasts to achieve symmetry.
- Morbid Obesity-Coverage for non-experimental, surgical treatment if the Morbid Obesity has persisted for at least five (5) years and non-surgical treatment supervised by a licensed physician for at least eighteen (18) months has been unsuccessful. Note: You must be able to provide documentation to support the Member's medically supervised multi-disciplinary weight loss program as outlined above.

Morbid Obesity means:

1. a weight of at least two (2) times the ideal weight for a Member's frame, age, height, and gender, as specified in the most current Metropolitan Life Insurance tables;
2. a body mass index of at least thirty-five (35) kilograms per meter squared, with comorbidity coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
3. a body mass index or at least forty (40) kilograms per meter squared without comorbidity.

Note: Body mass index is equal to weight in kilograms divided by height in meters squared.

b. COPAYMENT AND LOCATION OF SERVICE PROVIDED
   i. Minor surgery in Contracting Physician's or approved referral Physician's Office: The Physician Office Visit copayment applies to each visit.
   ii. Inpatient or outpatient surgery in a Contracting Hospital: The Inpatient Medical Hospital and outpatient Surgery Services Copayments listed on the Application to the Contract and the Certificate of Coverage.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

Surgical procedures require a Proper Referral by Your PCP and then must be performed by a Contracting Physician or the authorized referral Physician. They must be provided in the Physician's office or in a Contracting physician office , or the properly authorized referral Hospital, outpatient facility, or surgical center specified by the PCP.

14. HOSPITAL AND ANESTHESIA SERVICES FOR DENTAL CARE

a. BENEFIT

Hospital and anesthesia services related to dental care, if:

i. The Member is under age 19, or is age 19 or over and has a record of, or is regarded as having a physical or mental impairment that substantially limits one or more of his/her major life activities;
ii. Your mental or physical condition requires that dental care be provided in a Hospital or outpatient surgical center;

The dental procedure is excluded under this Contract.

b. COPAYMENT
i. Inpatient – The Inpatient Medical Hospital Copayments listed on the Application to the Contract and the Certificate of Coverage;
ii. Outpatient – The Outpatient Surgery Services Copayment list on the Application to the Contract and the Certificate of Coverage.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
Procedure must be performed at a Contracting Hospital or Contracting Provider ambulatory outpatient surgical facility; Dental procedure is provided by a licensed dentist who has privileges at the Contracting Hospital or Contracting Provider ambulatory outpatient surgical facility.

15. BLOOD AND PLASMA
a. BENEFIT
Whole blood, Blood Plasma, Blood Derivatives
b. COPAYMENT
No Copayment
c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
Contracting Hospital

16. AMBULANCE TRANSPORTATION
a. BENEFIT
Emergency or other Medically Necessary ambulance, medi-van or similar medical ground, air or water transport to or from Hospital or both ways. Transfer from a hospital to a lower level of care covered only when Medically Necessary.
b. COPAYMENT
The Medically Necessary Ambulance Transport Copayment listed on the Application applies to each transport.
c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
Emergency ambulance services may be provided by any ambulance service. We must verify that Emergency Medical Services were required for the transportation to be covered. The other medical transportation services listed above must be Properly Referred by Your PCP and provided by a Contracting Provider.

17. SHORT TERM CARDIAC REHABILITATION
a. BENEFIT
Short term services that may be medically necessary for the improvement of cardiac disease or dysfuntion. Cardiac Rehabilitation may be necessary for patients with but not limited to post myocardial infarction (heart attack), post coronary bypass, post cardiac transplant, angina pectoris (Class II or IV), myocardial disease (Class III or IV), and dangerous arrhythmia's.
b. COPAYMENT
i. Short term outpatient cardiac rehabilitation: The Therapies Outpatient Copayment applies to each visit.
ii. Short term inpatient cardiac rehabilitation: Same as inpatient Medical Hospital Copayment/Coinsurance for each admission.
c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
i. Short term outpatient rehabilitation services must be provided, upon Proper Referral from the Member's PCP, by a Contracting Provider of cardiac rehabilitation services.
ii. Short term inpatient cardiac rehabilitation services must be provided, upon Proper Referral from the Member's PCP, by a Contracting Hospital or Contracting Skilled Nursing Facility ("SNF")

18. SHORT TERM PHYSICAL THERAPY
a. BENEFIT
Short term physical therapy – covered with Proper Referral by Your PCP for a condition which the PCP believes is subject to continuing improvement. Chiropractic services are limited to subluxation only and subject to the benefits, limitations and exclusions of short-term physical therapy.

b. COPAYMENTS
   i. Short term outpatient physical therapy: The Therapies Outpatient Copayment applies to each visit.
   ii. Short term inpatient physical therapy: Same as Inpatient Medical Hospital Copayment/Coinsurance for each admission.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
   i. Short-term outpatient therapy services must be provided, upon Proper Referral from Your PCP, by a Contracting Provider of physical therapy services.
   ii. Short-term inpatient physical therapy services must be provided, upon Proper Referral from Your PCP, by a Contracting Hospital or Contracting Skilled Nursing Facility ("SNF")

19. SHORT TERM PULMONARY REHABILITATION

a. BENEFIT

Short term services that may be medically necessary for the improvement of pulmonary disease or dysfuntion that has a poor response to treatment. Examples of poor response include but are not limited to patients with respiratory failure, frequent emergency room visits, progressive dyspnea, hypoxemia, or hypercapnia.

b. COPAYMENT
   i. Short term outpatient pulmonary rehabilitation: The Therapies Outpatient Copayment applies to each visit.
   ii. Short term inpatient pulmonary rehabilitation: Same as Inpatient Medical Hospital Copayment/Coinsurance for each admission.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
   i. Short term outpatient rehabilitation services must be provided, upon Proper Referral from the Member's PCP, by a Contracting Provider of pulmonary rehabilitation services.
   ii. Short term inpatient pulmonary rehabilitation services, must be provided, upon Proper Referral from the Member's PCP, by a Contracting Hospital or Contracting Skilled Nursing Facility ("SNF")

20. SHORT TERM SPEECH AND OCCUPATIONAL THERAPY

a. BENEFIT

Short-term speech or occupational therapy – services are covered with Proper Referral by Your PCP for a condition which the PCP believes is subject to continuing improvement and, if provided to correct an impairment due to:
   i. injury or sickness; or
   ii. a congenital defect.

Speech Therapy is covered when provided to restore speech after a loss or impairment of a demonstrated, previous ability to speak; or, to develop or improve speech after surgery to correct a defect that existed at birth and impaired, or would have impaired, the ability to speak.

b. COPAYMENT
   i. Short term outpatient occupational and speech therapy: The Therapies Outpatient Copayment applies to each visit.
   ii. Short term inpatient occupational and speech therapy: Same as Inpatient Medical Hospital Copayment/Coinsurance for each admission.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
   i. Short term outpatient occupational and speech therapy services must be provided, upon Proper Referral from Your PCP, by a Contracting Provider of such services.
   ii. Short term inpatient occupational and speech therapy services must be provided, upon Proper Referral from Your PCP, by a Contracting Hospital or Contracting Skilled Nursing Facility ("SNF").

21. HOME HEALTH SERVICES

a. BENEFIT

Medically Necessary Home Health Services, including:
   i. Skilled medical services. If continuous medical or skilled nursing services are required, ADVANTAGE may require transfer to SNF or other Contracting facility if medically appropriate and more cost effective.
   ii. Nursing care given or supervised by a Registered Nurse.
   iii. Nutritional counseling furnished or supervised by a registered dietician.
   iv. Home Hospice Services

v. Short term physical, speech and occupational therapy. (The physical therapy portion of this benefit is subject to the limitations and Copayments set forth under "Short Term Physical Therapy" and "Short Term Speech and Occupational Therapy.")
vi. Home health aides
vii. Medical supplies, lab services, drugs, and medicines prescribed by a physician in connection with home health care.
viii. Medical social services.
ix. Training of family members or significant other to provide those home health services that can be performed by lay persons.

Services are Covered Services only if they are not considered custodial care and the services are prescribed in writing by Your Contracting Physician:

- As Medically Necessary for the care and treatment of Your illness or injury at home
- As being in place of Inpatient Medical Hospital care or a convalescent nursing home that would be required in the absence of such services; and
- The services are furnished to You while under a Contracting Physician's care.

b. COPAYMENT

The Home Health Services Copayment listed on the Application applies to each visit, except that if Short Term Physical Therapy or Short Term Occupational or Speech Therapy is provided, then the Physical Therapy, Speech Therapy or Occupational Therapy Copayment will apply, respectively.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

Home health services must be provided, with Proper Referral by Your PCP, by a Contracting Provider of home health services in Your Home.

22. EXTENDED CARE SERVICES

a. BENEFIT

Up to the number of days listed on the Application per contract year of skilled nursing when Medically Necessary, with Proper Referral by Your PCP.

i. Semi-Private accommodations (Private room provided when Medically Necessary).
ii. Drugs, biologicals, medical social services, short term physical therapy and other services generally provided by SNFs. (The physical therapy portion of this benefit is subject to the limitations and Copayments set forth above under "Short Term Physical Therapy" and Short Term Speech and Occupational therapy.)
iii. Hospice care provided for terminally ill Member, in accordance with a treatment plan developed before admission to the hospice care program. The treatment plan must be approved by Us or Your PN. The treatment plan must include a statement from Your PCP documenting that Your life expectancy is six months or less.

b. COPAYMENT

SNF, Inpatient hospice or other extended care facility Copayment is specified on the Application to the Contract located at the front of the Contract and the Certificate of Coverage. Copayment waived if You are transferred from another Contracting inpatient facility.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

Extended care services must be provided by a Contracting Skilled Nursing Facility, a Contracting Hospice or other Contracting Provider. Proper Referral by Your PCP is required.

23. DIABETIC SUPPLIES

a. BENEFIT

You will be entitled to diabetic supplies as identified on the ADVANTAGE Diabetic Supplies Covered Item List when prescribed by either an ADVANTAGE Provider or other provider upon a Proper Referral; and subject to limitations and exclusions below:

i. Luxury items will only be covered if a non-luxury item is not available or the luxury item is deemed medically necessary for its intended purpose as prescribed and approved by an ADVANTAGE Physician.

b. LIMITATIONS

i. Except for the diabetic supplies purchased through the ADVANTAGE approved mail order program, quantity dispensed shall be limited to that sufficient to treat the diagnosis or a thirty (30) day supply, whichever is less, per Copayment.

c. COPAYMENT

Diabetic Supplies Copayment is specified on the Application to the Contract located at the front of the Contract and the Certificate of Coverage.

d. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

Most Diabetic Supplies must be provided by an ADVANTAGE Contracting Pharmacy or ADVANTAGE approved mail order program, with Proper Referral from Your PCP. However, insulin pumps and some other medically necessary Diabetic Supplies not available at an ADVANTAGE Pharmacy must be obtained by a Contracting Provider authorized by Your Physician Network.

24. DIABETIC SELF-MANAGEMENT TRAINING

a. BENEFIT

i. Outpatient diabetes self-management training ordered in writing by a Contracting Provider.

ii. Inpatient diabetes self-management training is covered under Inpatient Medical Hospital.

iii. Diabetes management training is limited to:

1. One visit after receiving a diagnosis of diabetes;
2. One visit after receiving a diagnosis that represents a significant change in Your symptoms or condition and make changes in Your self-management Medically Necessary; and
3. One visit for re-education or refresher training.

b. COPAYMENT

No Copayment applies.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

A licensed, registered, or certified health care professional that has specialized training in the management of diabetes.

25. INJURY TO SOUND AND NATURAL TEETH

a. BENEFIT

Members with injury to sound and natural teeth (ISNT) will be entitled to the following medical ISNT benefits only if so indicated on the Application for Contract and indicated on the Face Sheet of the Certificate of Coverage.

i. Injured teeth must be sound and natural, including teeth that have been filled, capped, or crowned. Includes dentally indicated services to repair or replace sound and natural teeth when the injury is traumatic. A traumatic injury is defined as an injury to living tissue caused by an extrinsic agent.

ii. Injury is caused by the force of an external object striking the tooth.

iii. Injury must be reported to PCP immediately, and treatment must be south with a Proper Referral to a Contracting Provider within a 72-hour period. After emergency treatment, follow-up care must be referred by PCP and initiated within sixty (60) days of injury. All treatment must be completed within one year from the initiation of treatment and Accident must have been incurred on or after the effective date of coverage.

b. EXCLUSIONS

i. All unauthorized services, or services rendered by a non-contracting Provider.

ii. All services not completed within one year from initiation of treatment.

iii. Repair of injury caused by an intrinsic force, such as the force the upper and lower jaw in chewing.

iv. Repair of artificial teeth, dentures or bridges.

c. COPAYMENTS

The Copayment for ISNT services is listed on the Application to the Contract and indicated on the Face Sheet of this Certificate of Coverage.

d. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

Services must be provided by a Contracting Provider dentist or oral surgeon or other ADVANTAGE designated facility.

26. THERAPEUTIC INJECTIONS

a. BENEFIT

Members with therapeutic benefits will be entitled to the following medical therapeutic injection benefits only if so indicated on the Application attached to the Certificate of Coverage.

Outpatient therapeutic injections which are Medically Necessary and which may not be self-administered. Injections include, but are not limited to chemotherapy, antibiotics, analgesics, hydration, total parenteral nutrition (TPN), Prolastin, and Factor 8 injections which are Medically Necessary.

b. EXCLUSIONS

Excludes insulin injections, which may be covered under the Prescription Drug Rider, if so elected on the Application to the Contract and on the Face Sheet of the Certificate of Coverage.

c. COPAYMENT
The Copayment for therapeutic injection services is listed on the Application to the Contract and indicated on the Face Sheet of the Certificate of Coverage.

d. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
Therapeutic injections must be provided by Your PCP, or, with Proper Referral, by a Contracting Physician.

27. NUCLEAR MEDICINE

a. BENEFIT
For tests or treatments using radioactive materials.

b. COPAYMENT
No Copayment

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED
Nuclear medicine must be provided by a Contracting Provider, with Proper Referral from Your PCP.

28. DIALYSIS

a. BENEFIT
Outpatient or Inpatient dialysis services coordinated and authorized under Proper Referral.

b. COPAYMENT
i. Outpatient – The Physician Office Visit Copayment applies;
ii. Inpatient – The Inpatient Medical Hospital Copayment applies.

c. WHO MUST PROVIDE SERVICES FOR IT TO BE COVERED
Services must be provided by a Contracting Physician and/or Contracting facility, through a Proper Referral.

29. HEALTH EDUCATION

a. BENEFIT
i. Health education is provided by PCPs as part of preventive health care coverage.
ii. Classes in nutrition, smoking cessation, and other health education topics are provided by ADVANTAGE from time to time.

b. COPAYMENT
No Copayment applies to health education provided by the PCP as part of preventive health care.

c. WHO MUST PROVIDE SERVICES FOR IT TO BE COVERED
Your PCP and ADVANTAGE offer some health education programs at their facilities from time to time. Other programs and locations must be pre-approved by ADVANTAGE.

30. MEDICAL SOCIAL SERVICES

a. BENEFIT
Medical social services to assist members and their families in understanding and coping with the emotional and social problems, which affect their health status.

b. COPAYMENT
No Copayment

c. WHO MUST PROVIDE SERVICES FOR IT TO BE COVERED
The staff of the Hospital to which You have been properly referred or a Contracting Provider.

31. TRANSPLANTS

a. BENEFITS
Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a Member; Includes a maximum lifetime limit of $10,000 for Covered Services related to transportation and lodging for the donor. The maximum lifetime limit for Covered Services related to transportation and lodging applies to the Policy Maximum. No coverage is provided for the donor or the recipient when the recipient is not a Member.

Non-experimental, non-investigational organ and other transplants are covered as follows, subject to the exclusions and limitations of the Contract and Our screening criteria: We currently accept as non-experimental/non-investigational the following: Cornea; Kidney; and, in accordance with Medicare guidelines and Our screening criteria, Heart, Lung, Heart-Lung, Pancreas and Liver. Autologous bone marrow transplants are currently covered only for acute non-lymphocytic or lymphocytic leukemia, Hodgkin's Disease and neuroblastoma. Allogenic bone marrow transplants are currently covered only for aplastic anemia, severe combined immunodeficiency disease (SCID), certain hereditary blood disorders, Hodgkin's and non-Hodgkin's lymphoma, chronic myelogenous leukemia, and acute lymphocytic or non-

lymphocytic leukemia. Bone marrow transplants for solid tumors, such as breast cancer, may be considered experimental and may not be covered. However, if a patient has locally advanced breast tumor or has partially responded to chemotherapy, but suffered a recurrence of the cancer after being cancer free for at least nineteen (19) months, We will, upon request, send the Your medical records to several independent ombudsmen for a recommendation of whether to cover an Autologous bone marrow transplant. We will make a decision as to whether to cover the case based on the recommendations of the majority and based on Our screening criteria.

b. EXCLUSIONS

All other transplants are currently excluded. Donor costs are not covered if they are payable in whole or in part by any other organization, or person (other than the donor's family or estate), except that, if covered in part by insurer, Coordination of Benefits may apply. Donor costs are not covered if the recipient of the transplant is not an ADVANTAGE Member. Services, supplies, and drugs given, arranged for or provided in connection with artificial or mechanical heart transplants, or ventricular or atrial assist devices are not covered.

c. COPAYMENT

Inpatient Care – The Inpatient Medical Hospital Copayment listed on the Application to the Contract and the Certificate of Coverage.

d. WHO MUST PROVIDE SERVICES FOR IT TO BE COVERED

Transplant services must be provided by a Contracting Hospital or an authorized referral facility experienced in performing that type of transplant. All transplants require Proper Referral by Your PCP.

32. PERVASIVE DEVELOPMENTAL DISORDER (PDD)

a. BENEFIT

Pervasive Developmental Disorder is defined as a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

Benefits for Pervasive Developmental Disorder include but are not limited to:

- Evaluation and Testing to confirm diagnosis
- Physical, speech, occupational therapy
- Dietary evaluation

Benefits are limited to treatment that is prescribed by a physician in accordance with the patient's treatment plan.

No other exclusions or limitations in the Certificate of Coverage that conflict with this benefit apply.

b. COPAYMENT

Inpatient Care – Same as Inpatient Medical Hospital Copayment/Coinsurance listed on the Application to the Contract located at the front of this Certificate of Coverage.

Outpatient Care – Pervasive Developmental Disorder and/or Autism Copayment/Coinsurance same as outpatient therapies' copay as indicated on the Application to the Contract located at the front of this Certificate of Coverage.

c. WHO MUST PROVIDE SERVICES FOR IT TO BE COVERED

i. Inpatient care must be provided, upon Proper Referral from Your PCP, by a Contracting Hospital or SNF unless services are not available there. In that case, the services may be provided in a referral Hospital, upon Proper Referral and authorization. If You are admitted to a non-contracting Hospital following Emergency Medical Services, that Hospital may provide Covered Services until such time as You are well enough, in the opinion of the treating physician, to be transferred to a Contracting Hospital.

ii. Outpatient care must be provided by Your PCP or upon Proper Referral from Your PCP, by a Provider of such services.

33. SUBSTANCE ABUSE (REHABILITATION SERVICES)

a. BENEFIT

Detoxification for alcohol or other drug addiction is covered on an inpatient and/or outpatient basis, whichever is determined to be Medically Necessary. To be covered, it must be authorized by Your designated Behavioral Health Provider Network. The benefit is subject to the limitations set forth below and the limits on the maximum number of days per contract year specified on the Application located at the front of this Contract.

b. LIMITATION

i. The treatment setting, e.g., inpatient, outpatient, residential or transitional, for the treatment of alcohol or other drug dependency shall be determined by Your Behavioral Health Provider designated by Us in accordance with medical necessity.

ii. Detoxification is limited to 2 admissions per lifetime.

iii. The number of rehabilitation days covered if coverage elected is specified on the Application at the front of this Contract and represents the days per contract year of inpatient or intensive outpatient daycare. Depending on the level of care Medically Necessary for the treatment of alcohol or other drug dependency, covered inpatient days will be counted against the rehabilitation day limitations as follows:

- One (1) inpatient day = one (1) residential day
- One (1) extended day outpatient treatment = one half inpatient day

c. COPAYMENT

The Substance Abuse copayment for Detoxification Services specified on the Application to the Contract located at the front of this Contract and the Certificate of Coverage.

d. LOCATION WHERE SERVICE MUST BE PROVIDED TO BE COVERED

Medical facilities or hospitals (special or general) associated with Your assigned Behavioral Health Provider.

Detoxification and Rehabilitation Services Rider

a. BENEFIT

Members shall be entitled to the following substance abuse services, only if elected as a rider on the Application for Contract located at the front of this Contract and the Certificate of Coverage.

i. Detoxification and Rehabilitation for alcohol or other drug addiction is covered on an inpatient and/or outpatient basis, whichever is determined to be Medically Necessary. To be covered, it must be authorized by the Member's designated Behavioral Health Provider Network. The benefit is subject to the limitations set forth below and the limits on the maximum number of days per contract year specified on the Application for Contract. Treatments to be provided as Medically Necessary, shall include:

- Medical evaluations;
- Psychiatric evaluations;
- Inpatient and outpatient care;
- Psychotherapy and counseling (individual and group);
- Drug therapy (for rehabilitation only);
- Behavior and recreation therapy (inpatient only);
- Family therapy;
- Drugs and supplies dispensed in covered settings.

b. LIMITATION

i. The treatment setting, e.g., inpatient, outpatient, residential or transitional, for the treatment of alcohol or other drug dependency shall be determined by the Member's Behavioral Health Provider designated by Us in accordance with medical necessity.

ii. Detoxification is limited to 2 admissions per lifetime.

iii. The number of rehabilitation days covered if coverage elected is specified on the Application to the Contract and represents the days per contract year of inpatient or intensive outpatient daycare. Depending on the level of care Medically Necessary for the treatment of alcohol or other drug dependency, covered inpatient days will be counted against the rehabilitation day limitations as follows:

- One (1) inpatient day = one (1) residential day
- One (1) extended day outpatient treatment = one half inpatient day

c. COPAYMENT

The Substance Abuse Copayment specified on the Application to the Contract and the Certificate of Coverage.

d. LOCATION WHERE SERVICE MUST BE PROVIDED TO BE COVERED

Medical facilities or Hospitals (special or general) associated with Your assigned Behavioral Health Provider or designated affiliated residential, outpatient or transitional care facilities. Transitional care means temporary (usually 8-12 hours) out-of-home placement or in-home treatments (as described above) which will provide for the immediate needs of a Member until residential or outpatient facilities become available.

34. MENTAL HEALTH

(i) Crisis Intervention Only

a. BENEFIT

Services related to crisis intervention only until You are stabilized. Stabilized means to provide medical treatment to a Covered Person in an Emergency, as may be needed to assure, within reasonable medical probability, that material deterioration of his condition is not likely to result, if he/she is discharged or transferred.

(ii) Mental Health Rider

a. BENEFIT

You will be entitled to the following psychiatric services, to the extent elected as rider on the Application for Contract and indicated on the Face Sheet of the Certificate of Coverage, subject to Proper Referral from Your ADVANTAGE Provider for mental health services including the treatment for Autism and Pervasive Developmental Disorders (PDD), and for which the Provider believes is subject to continuing improvement.

i. Inpatient Psychiatric hospital services, including evaluation and treatment in a psychiatric day treatment facility, when Medically Necessary, ordered by Your designated ADVANTAGE Provider for mental health services and authorized by the UM Committee.

ii. Outpatient visits will be provided, up to the maximum number of visits specified on the Application to the Contract, if Medically Necessary and when ordered by Your ADVANTAGE Provider for mental health services.

b. COPAYMENT

i. Outpatient Mental Health Services: The Outpatient Mental Health Copayment applies to each visit.

ii. Inpatient Mental Health Services: Same as Inpatient Medical Hospital Copayment/Coinsurance for each admission.

c. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

i. Outpatient: Mental Health Services must be provided, upon Proper Referral from Your ADVANTAGE Provider for mental health services, by a contracting Provider of mental health services.

ii. Inpatient: ADVANTAGE Provider for Mental Health services, by a Contracting Hospital.

35. PRESCRIPTION DRUG RIDER

a. BENEFIT

You will be entitled to the following prescription drug services from a Contracting Pharmacy only and subject to the limitations and exclusions below: if indicated on the Application pages attached to the front of this Contract and Certificate of Coverage; when prescribed by either an ADVANTAGE Provider or other provider upon a Proper Referral; when approved by the Food and Drug Administration (FDA); when prescribed for an (FDA) approved indicated, dosage, and route of administration, and subject to the limitations and exclusions below:

i. All drugs requiring a prescription either by State or Federal law, except injectables (other than Insulin).

ii. All compound prescriptions that contain at least one covered prescription ingredient.

iii. Insulin and insulin needles and syringes, when prescribed by an ADVANTAGE Physician and dispensed for sole use of You.

b. LIMITATIONS

i. All prescriptions must be filled with the most cost effective FDA approved generic medications, if any, and in accordance with the Outpatient Prescription Drug Rider copayments listed on the Application at the front of this Contract.

ii. Except for maintenance prescriptions filled through the ADVANTAGE approved mail order program, quantity dispensed shall be limited to that sufficient to treat acute phase of illness or a thirty (30) day supply, whichever is less, per Copayment.

iv. You will be reimbursed, less the applicable Copayment, for prescription drugs obtained from other than the designated ADVANTAGE Pharmacies, only when the drug was:

1. Ordered in connection with an out-of-area emergency covered under the Emergency medical Services Section of the Contract;

2. Ordered by a physician for immediate use because of medical necessity and because Your designated pharmacy is not open for business at that time. Reimbursement in the above two circumstances will be limited to the usual, customary, and reasonable cost of a quantity of the drug sufficient to treat the acute phase of the illness or to a maximum of thirty (30) day supply, whichever is less, and will be subject to the Copayment defined under "Copayment Required."

iv. A drug not approved by the FDA may be prescribed if one of the following conditions are met (a) the drug is recognized for treatment of the indication in at least one (1) standard referenced compendium; or (b) the drug is recommenced for that particular type of cancer and found safe and

effective in informal clinical studies; the results which are published in United States or Great Britain.

c. EXCLUSIONS

The following are not covered:

i. Injectables other than insulin;
ii. Implantable drugs; implantable devices for the administration of drugs;
iii. Devices and appliances other than insulin syringes/needles (e.g., diaphragms, cervical caps or intrauterine devices (IUDs);
iv. Drugs administered in physician's offices, hospitals, nursing homes, ADVANTAGE Skilled Nursing Facilities and hospices;
v. Except for Nicotine Patches all over the counter (OTC) drugs;
vi. Drugs whose purpose is the treatment of infertility or impotence;
vii. Except for drugs approved through the ADVANTAGE review process, drugs prescribed that are investigative or experimental in nature. A drug shall be considered experimental if it has not been approved by the FDA and if the FDA has not approved the drug for the route of administration, the dosage involved, or except as otherwise required by law for certain cancer drugs, the specific indications for which the drug is being prescribed.
viii Drugs used for cosmetic or recreational purposes (e.g., anabolic steroids, anorexiants, topical minoxidil, or Retin-A for wrinkles, however, retonic acid creams are covered when used in connection with the treatment of severe acne.) Drugs prescribed as part of the treatment for congenital defects or anomalies, shall not be considered cosmetic for purposes of this Section.
ix. Nicotine gum, clonidine patches or other drugs or Brand Name Prescription devices prescribed primarily for the cessation of smoking except for Nicotine Patches.
x. Anorexiants, food supplements and other drugs when prescribed for the treatment of obesity.
xi. Hospital discharge drugs; take-home drugs.
xii. Oral prescription medications when prescribed for foreign travel.
xiii. Growth hormones.
xiv. Replacement of drugs due to loss, theft or negligence.
xv. Maintenance drugs when filled at a Non-ADVANTAGE contracted pharmacy Provider.
xvi. Birth Control Drugs that require a prescription.

d. COPAYMENT

The Copayments for Outpatient Prescription Drug Rider are listed on the Application to the Contract and indicated on the Application pages attached to the Certificate of Coverage.

e. LOCATION WHERE SERVICE MUST BE PROVIDED TO BE COVERED

Services must be provided at an ADVANTAGE designated Pharmacy or ADVANTAGE approved mail order program.

f. EXCLUDED PRESCRIPTIONS

Excluded prescriptions may be purchased at a participating ADVANTAGE Contracting Pharmacy Provider at ADVANTAGE's negotiated discount price.

36. DURABLE MEDICAL EQUIPMENT RIDER (DME)

a. BENEFIT

Rental or purchase of durable medical equipment; You shall be entitled to the following durable medical equipment services, only if so indicated on the Application for Contract and the Certificate of Coverage and authorized by Proper Referral by the Your PCP or PN.

i. Durable medical equipment when Medically Necessary, ordered by an ADVANTAGE Physician and authorized by Us or the PN.
ii. Durable medical equipment when Medically Necessary equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of illness or injury and is suitable for use in Member's home. Examples of DME include, but are not limited to, wheel chairs, crutches, respirators, traction equipment, hospital beds, monitoring devices, oxygen-breathing apparatus.
iii. Training in the use of any medically necessary covered DME is also covered.
iv. Rental payments apply to purchase of equipment.

b. LIMITATIONS AND EXCLUSIONS

i. Non-durable equipment, i.e., equipment that cannot withstand repeated use, is not covered.
ii. Equipment that is not medical or not primarily and customarily used to serve a medical purpose is not covered; nor is equipment that services a useful purpose in the absence of illness or injury.
iii. Equipment that is not suitable for use in the home is not covered.
iv. Examples of items that are NOT covered by this rider: eyeglasses and contact lenses, except for the first pair following optical surgery; corrective shoes; arch supports; hearing aids; dental

prostheses; deluxe equipment; common first aid supplies; and non-durable supplies unless they are required to operate a durable medical device approved by Us or the PN and are an integral part of the DME set-up.

v. You shall be entitled only to the basic type of durable medical equipment necessary to provide for Member's medical and/or the Utilization Management Committee.

vi. Items and equipment specifically fitted to an individual and not appropriate for repeated use by multiple patients, such as those which replace all or part of an external body part or all or part of the function of a permanently inoperative or malfunctioning internal body organ. These types of equipment are considered under the Corrective Appliances and Artificial Aides Rider and coverage under that benefit rider has been elected on the Application at the front of this Contract.

c. COPAYMENT

The Copayment for Durable Medical Equipment Rider is specified on the Application to the Contract located at the front of this Contract and Certificate of Coverage.

d. LOCATION WHERE SERVICE MUST BE PROVIDED TO BE COVERED

Services must be provided in Your home. Services must be provided by an ADVANTAGE designated facility or an ADVANTAGE contracted durable medical equipment supplier.

37. CORRECTIVE APPLIANCES AND ARTIFICAL AIDES

a. BENEFIT

i. Prosthetic or orthotic appliances which are Medically Necessary. Such appliances must be used to restore function or to replace body parts. They must be provided with Proper Referral from the member's PCP and as prescribed by the Contracting Physician. Examples of corrective appliances that would be covered if Medically Necessary and prescribed by a Contracting Physician include, but are not limited to, pacemakers, hemodialysis equipment, breast prostheses, prosthetic limbs, back braces, and if prescribed to correct a musculoskeletal malalignment, foot orthotics.

ii. Purchase, replacement, or adjustment of artificial limbs or eyes, when required due to a change in the Covered Person's physical condition or body size, due to normal growth.

b. EXCLUSIONS

i. Appliances and aids which are not necessary for the restoration, function or replacement of a body part are not covered.

ii. Other examples of items that are NOT covered under this rider: non-durable appliances; hearing aids; glasses (except one pair following cataract surgery); dental appliances; and dentures.

c. COPAYMENT

See Application for Copayment

d. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

Corrective appliances must be provided by a Contracting Provider, with Proper Referral from Your PCP or PN.

38. TEMPOROMANDIBULAR JOINT (TMJ) DISORDER AND ORTHOGNATHIC CONDITIONS

a. BENEFIT

Covered Services include diagnosis and treatment of:
TMJ disorders; And orthognathic conditions

b. LIMITATIONS AND EXCLUSIONS

These benefits are limited to a benefit plan maximum and must be pre-authorized by the Member's PCP. The benefit plan maximum applies to both TNJ and Orthognathic disorders.
The benefit plan maximum applies to Orthognathic conditions.
The benefit plan maximums are specified on the application to the Contract located at the front of this contract.

c. COPAYMENT

The copayment for TMJ Disorder and Orthognathic conditions are specified on the Application to the Contact located at the front of this Contract.

d. WHO MUST PROVIDE SERVICE FOR IT TO BE COVERED

Covered services must be provided by a Contracting Provider, with Proper Referral from the Member's PCP or PN.

MISSED APPOINTMENTS

Members who miss scheduled appointments without canceling with reasonable notice may be charged by the provider for missed appointments.

ARTICLE VII – OTHER EXCLUSION AND LIMITATIONS ON BENEFITS

The following services are not covered under this Certificate of Coverage and are thus Your financial responsibility.

1. Services and supplies that are not performed, arranged, authorized, or approved in advance by Your PCP, except as specifically stated in the Contract.
2. Services and supplies that are:
    a. not Medically Necessary;
    b. not specifically listed as Covered Services;
    c. not within the scope of the Provider's license;
    d. furnished by a government plan, Hospital, or institution, unless You are legally required to pay for the service;
    e. provided prior to Your Effective Date of Coverage or after Your Coverage is terminate; or
    f. incurred after You leave a program of Inpatient care for the same condition, against the medical advice of his Physician.
3. Services and supplies that would have been provided at no cost if You did not have Coverage under this Plan.
4. Services and supplies which are covered, or would have been covered, under any worker's compensation or occupational disease act or law.
5. Services and supplies provided to treat an illness or injury caused by:
    a. any act of declared war;
    b. service in the military forces of any country, including non-military units supporting such forces;
    c. the commission or attempt to commit a civil or criminal battery or felony; or
    d. taking part in a riot ("taking part in a riot" means the use or threat to use, force or violence without authority of law, by four or more persons).
6. All treatments, procedures, facilities, equipment, drugs, devices, services, or supplies that are considered investigational.
7. Except for services covered in accordance with the Women's Health and Cancer Act of 1998 cosmetic or reconstructive procedures, and any related services or supplies, which alter appearance, but do not restore or improve impaired physical function.
8. Services and supplies provided to treat hair loss, promote hair growth, or remove hair. However, You are entitled to access Our discount for such drugs through a Contracting Pharmacy.
9. Services and supplies related to narcotic maintenance treatment for opiate addiction.
10. Storage of blood products when not Medically Necessary or not provided in conjuction with a scheduled covered surgery; blood products when replaced by donation.
11. Items or devices primarily used for comfort, including, but not limited to air purifiers, humidifiers, dehumidifiers, whirlpools, air conditioning, waterbeds, exercise equipment, and ultraviolet lighting.
12. Non-Skilled Care, rest cures, respite care, or domiciliary care, regardless of the setting.
13. Services and supplies provided by Your Dependent, parent, brother, sister, or child, or someone who lives with You.
14. Private duty nursing services provided for the convenience of You or the convenience of the family (for example, bathing, feeding, exercising, moving the patient, giving oral medication or acting as a companion or sitter).
15. Room and board services while You are permitted to temporarily leave a Hospital, Skilled Nursing Facility, or Hospice Facility.
16. Orthodontia and other dental services, except as expressly provided for in this Certificate.
17. Refractive surgery performed to treat myopia or hyperopia.
18. Physical exams and related x-ray and lab expenses, when provided for employment, school, travel, immigration, or insurance purposes. Pre-marital tests or exams. Other services and/or supplies which are not, in the judgement of Your Physician, Medically Necessary for the maintenance or improvement of Your health.
19. Except for autism and Pervasive Developmental Disorders services and supplies for the treatment of:, adult hyperkinetic syndrome, learning disabilities, mental retardation, behavioral disorders, developmental delay or disorder, or senile deterioration, beyond the period necessary to diagnose the condition.
20. Marriage counseling, personal growth therapy, or sex counseling or therapy.
21. Hypnotherapy, behavioral modification, or milieu therapy, when used to treat conditions that are not recognized as mental disorders by the American Psychiatric Association.
22. Services and supplies unrelated to mental health for the treatment of co-dependency or nicotine or caffeine addiction. Self-help training and other related forms of non-medical self care, which are unrelated to mental health.
23. Immunizations provided for the purpose of travel.
24. Supportive devices of the feet, care of flat feet, fallen arches, weak feet, chronic foot strain, and toenails, and treatment of corns, bunions, and calluses. However, care of corns, bunions, calluses, or toenails is covered when Medically Necessary because of diabetes or circulatory problems.
25. Telephone consultants, charges for completion of claim forms, or charges for failure to keep scheduled appointments.
26. Court-ordered services, unless appropriate, Medically Necessary, and authorized by the PCP.
27. Travel or hospitalization for environmental change, or Physician services connected with prescribing environmental changes.
28. Naturopathic medicine or Christian Science medicine.
29. Acupuncture, except where administered by a Participating Provider and used as an anesthetic agent for covered surgery.
30. Preparation of special medical records or court-ordered appearances for hearing or proceedings.
31. Medical care provided outside the U.S., unless an Emergency.

32. Except as expressly provided for in this Policy, chiropractic services of a Chiropractor.
33. Services, drugs, and supplies for weight loss, diet, health or exercise programs, health clubs dues, or weight reduction clinics. However, You are entitled to access Our discount for such drugs through a Contracting Pharmacy.
34. Vision examinations, eyeglasses and their fitting, unless Medically Necessary following cataract surgery. Vision therapy, including eye exercises, is also excluded.
35. Unless Outpatient Prescription Drug Rider is indicated on the Application pages at the front of this Certificate of Coverage Prescription drugs, except when used during:
    a. an Inpatient Admission; or
    b. Outpatient hospital services. However, You are entitled to access Our discount on such drugs through a Contracting Pharmacy.
36. Services or supplies for, or related to:
    a. sex change operations or reversal, except for congenital deficiency;
    b. artificial insemination
    c. gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or in-vitro or in-vivo fertilization;
    d. testing, treatment, or medication for the primary purpose of achieving conception; However, You are entitled to access Our discount on such drugs through a Contracting Pharmacy.
    e. infertility or impotency testing or treatment; However, You are entitled to access Our discount on such drugs through a Contracting Pharmacy.
    f. penile prosthesis
    g. abortion
    h. voluntary sterilization or reversal of sterilization;
    i. birth control drugs, supplies, or devices; However, You are entitled to access Our discount through a Contracting Pharmacy.
    j. use of surrogate for any reason
37. Hearing exams, except as expressly provided for in this Certificate, hearing aids, hearing therapy, or cochlearimplants and their fitting.
38. Extensive long-term neuromuscular rehabilitation, i.e., physical, speech or occupational therapy is excluded. Rehabilitation which the physician reasonably believes will require in excess of sixty (60) visits per each distinct condition or episode, beginning with the first rehabilitation treatment for that condition, will be considered “long-term” and is not covered. (When You undergo a rehabilitative treatment for a specific and distinct condition, that visit constitutes one treatment.)
39. Personal comfort items, including but not limited to services and supplies not directly related to Your care, such as guest meals and accommodations, private room (unless Medically Necessary), personal hygiene products, telephone charges, travel expenses (other than approved ambulance services as provided in the basic health services), take-home supplies including prescription drugs and similar items.
40. Mental Health services, except as otherwise described as Covered Services in the Contract and Certificate of Coverage.
41. Substance Abuse Benefits except as otherwise described as Covered Services in the Contract and Certificate of Coverage
42. Medical or Hospital services for treatment of alcoholism or drug addiction except as otherwise described as Covered Services in the Contract and Certificate of Coverage.
43. Durable medical equipment, unless provided under rider elected on the Application attached to the front of the Contract and Certificate of Coverage.
44. Non-durable medical supplies for use outside the Hospital or physician office.
45. Service obtained by a Member from physicians, Hospitals or other providers not associated with Us, either within the Service Area or outside the Service Area (except Emergency Services or upon Proper Referral by a Contracting Physician).
46. Recreational or educational therapy.
47. Treatment and testing for adolescents and children, which are state mandated services by or of the school system, unless therapy is deemed Medically necessary by the ADVANTAGE Contracting Provider.
48. Court ordered therapy, unless appropriate, Medically Necessary, and authorized by Your Contracting Behavioral Health Provider.
49. Vocational Therapy.
50. Lifestyle drugs are not covered. However, You are entitled to access Our discount on such drugs through a Contracting Pharmacy. For the purpose of this exclusion, Lifestyle drugs means those drugs prescribed for reasons such as, but not limited to: cosmetic preparations, hair loss treatments, weight reduction therapies, sexual dysfunction and smoking cessation products.

LIMITATIONS

(1) COST EFFECTIVENESS. We will not pay the cost of any inpatient or other care which could have been provided in an ADVANTAGE Physician’s office, in the outpatient department of a Hospital, or in another less costly location without adversely affecting the patient’s condition or the quality of medical care rendered, unless the UM Committee has determined the care to be medically indicated. Nor will We pay the cost of any service or article

which is significantly more expensive than an available alternative, unless the UM Committee has determined the more expensive service or article has been demonstrated to be of significantly greater therapeutic value than the other, less expensive, alternative.

(2) CIRCUMSTANCE BEYOND ADVANTAGE'S CONTROL

Neither, We, Hospitals, nor any ADVANTAGE provider shall have any liability or obligation for delay or failure to provide health care services:

(i) Due to causes beyond the control of Us or Our Providers. Such causes might include: complete or partial destruction of facilities, war, riot, civil insurrection, disability of a significant part of the Hospital personnel or Health Professionals, or similar causes, under which the rendition of medical or Hospital Services hereunder is delayed or rendered impractical.

(ii) Due to lack of available facilities or personnel if caused by disaster or epidemic.

In such events, physicians and Hospitals shall render medical and Hospital services insofar as practical, according to their best judgement, within the limitation of such facilities and personnel as are then available.

(3) EXPERIMENTAL TREATMENT, PROCEDURE, DRUG OR DEVICE AND NEW TECHNOLOGY

We provide a process to evaluate new medical technologies, services and pharmacological treatment to assure appropriate access to such services by the member population. We develop protocols for new technology proactively and reactively. As We become aware of new technology, the new technology guidelines outlined in this process are followed to prepare Our position regarding the new technology in anticipation of a future request.

We have available participating specialists, sub-specialists, pharmacists, and a referral center to assist with the review and determination regarding new medical technology. Your Primary Care Physician must request an approval, prior to the service date and in writing, regarding the recommended treatment or service that is a new application new medical technology, experimental or investigative treatments and services.

A research of available literature and review with BioAsTec is performed by Our associates to determine the feasibility of the recommended treatment. BioAsTec, an assessment program resource, provided scientific analysis of complex technology issues. BioAsTec professionals include physicians, pharmacists, PhD.'s and expert advisors representing many areas of clinical practice and managed care operations.

BioAsTec uses five criteria for assessing new technology:

1. The technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigative settings

Requests for approval of new medical technology procedures/services that involve a Member whose health situation is life threatening will be resolved within 72 hours.

Technology assessments non-urgent situations should be submitted 5-7 days prior to the service date if possible to allow adequate time to investigate the proposed treatment or service.

A response to a written request for technology assessment is provided within 7 days of receiving all necessary information.

Medical Management notifies the PCP, SCP, and facility by telephone of the recommendation to approve or deny coverage within one business day.

Medical Management mails Notification letter to the PCP, SCP, and You within one business day of the determination.

In urgent situations, notification letter shall be faxed to the PCP and the SCP on the day of the determination.

If the Vice President of Medical Affairs and/or Medical Director deny a request for a new technology service/procedure, a denial notification letter is sent within two business day (unless the request is expeditious) to You, PCP, and SCP outlining the principle reason for the denial, criteria utilized, and the appeals process.

ARTICLE VIII – TERMINATION, CANCELLATION, RENEWAL AND REINSTATEMENT

TERMINATION OF CONTRACT RENEWAL

The Contract may be terminated or not renewed by Us with cause upon thirty-one (31) days prior to written notice for the following reasons:

(i) Material breach of the terms of the Contract by the GROUP;
(ii) There are no longer any Members of the GROUP who live, work or reside in the Service Area;
(iii) We cease to offer coverage in the Service Area;
(iv) Fraud or misrepresentations by the GROUP; or
(v) Other good and reasonable cause permitted by law; or
(vi) The sale of substantially all of the GROUP's assets or equity to another entity; the merger of the GROUP into another entity, where the GROUP is not the surviving entity.

TERMINATION OF COVERAGE FOR THE SUBSCRIBER AND ANY ELIGIBLE DEPENDENTS

(1) The coverage hereunder for the Subscriber and enrolled Eligible Dependents, if any, may be terminated by Us upon the occurrence of any of the following events:
  (i) The termination of the Contract;
  (ii) The nonpayment of premiums by the GROUP on account of such Subscriber.
  (iii) You move your primary residence outside of Our Service Area
  (iv) Upon thirty-one (31) days prior written notice by Us if:
    (a) You fail to pay supplemental charges (Copayments) required for Hospital or medical services, or contributions, if any; or
    (b) You are unable to establish and maintain a satisfactory Hospital or patient-Health Professional relationship with Our Contracting Hospitals and Health Professionals; or
    (c) You commit fraud against Us or a provider by, for example:
      (i) Allowing a non-Member to use Your identification card to obtain services.
      (ii) Making any false statement or representation on Your membership application.;
      (iii) Falsifying a prescription, stealing or otherwise misappropriating a prescription blank(s) or other property of a Contracting Provider of ADVANTAGE;
      (iv) Altering Your medical record; or
      (v) Obtaining similar drug therapy or prescriptions from two or more providers, without Proper Referral or without informing the providers of Your complete prescription profile, when done for the purpose of providing such prescriptions to someone other than the person for who the medication was intended or for the purpose of self-administration of multiple prescriptions without the knowledge or approval of Your PCP.
    (d) You behave in a violent or abusive manner toward the staff of an ADVANTAGE Physician, a Physician Network, or Us;
    (e) You otherwise repeatedly violate the terms of this Certificate or Our rules; or
    (f) For other good cause as may from time to time be permitted by law. If membership is terminated for any of the grounds specified in this section, all rights to service cease as of the date of termination and there is no right to convert to an individual plan.
    (g) You fail to cooperate with Us in Our administration of the Coordination Of Benefits provisions set forth in this Certificate.

APPEAL OF CANCELLATION

A Member who alleges that coverage has been canceled or not renewed because of his/her health status, need for health care services or exercise of his/her rights under the grievance procedure may request review by Us or by the Department of Insurance.

ARTICLE IX – GENERAL PROVISIONS

NOTICE OF MATERIAL PROVIDER CHANGE

We will provide written notice to You, within a reasonable time after learning of an action by a Contracting Provider which has a material effect on the GROUP or You. Examples of such actions may include: leaving Our network; material breach of contract; or being unable to perform key contract terms, but only if any of those actions affects You in a material way.

WORKER'S COMPENSATION
This Contract is not in lieu of and does not affect any requirement or coverage by Worker's Compensation Insurance.

RIGHTS TO COVERED SERVICES NOT TRANSFEREABLE
No person other than You is entitled to receive health care services or other benefits to be furnished by Us under this Certificate. The right to health care services or other benefits is not transferable.

RIGHT TO CHANGE CONTROL WHEN REQUIRED BY STATE LAW
If State law changes any provision of this Certificate during the contract year, this Certificate is deemed amended to conform with such state law. We reserve the right to terminate the contract and re-rate the contract based on the changes at the time of renewal of this Certificate.

ARTICLE X – COORDINATION OF BENEFITS WITH OTHER COVERAGE

COORDINATION OF BENEFITS
Some people have health care coverage through more than one plan at the same time. This coordination of benefits (COB) provision allows these plans to work together so that the total amount of all benefits will never be more than 100% of the total allowable expenses during any calendar year.

DEFINITIONS

ALLOWABLE EXPENSE means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (an HMO, for example) the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense or service that is not covered by any of the plans is not an *allowable expense*. The following are examples of expenses or services that are not *allowable expenses*:

1. If You are confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense (unless Your stay in a private hospital room is medically necessary or one of the plans routinely provides coverage for hospital private rooms.
2. If You are covered by two or more plans that compute their benefit payments on the basis of usually and customary fees, any amount above the highest of the usual and customary fees for a specific benefit is not an allowable expense.
3. If You are covered by two or more plans that provide benefits or services on the bases of negotiated fees and another plan that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangements shall be the allowable expense for all plans. Any amount above *the primary plan's* payment arrangement is not *an allowable expense*.
4. If You are covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangements shall be the *allowable expense* for all plans. Any amount above the *primary plan's* payment arrangement is not *an allowable expense*.
5. If You do not comply with a *primary plan's* provisions and as a result, the *primary plan* reduces its benefits, the amount of such benefit reduction is not an *allowable expense*.

CLAIM DETERMINATION PERIOD means a calendar year. However, it does not include any part of a year during which a person is not a Member or before the date this COB provision or a similar provision takes effect.

CLOSED PANEL PLAN is a plan that provides health benefits to You, primarily in the form of services, through a panel of providers that have contracted with or are employed by the plan. A *Closed Panel Plan* limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

CUSTODIAL PARENT means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year, without regard to any temporary visitation.

PLAN means any contract that offers health care benefits or services through:

1. group insurance;
2. *closed panel* or other forms of group or group-type coverage, whether insured or uninsured;
3. hospital indemnity benefits in excess of $200 per day;
4. medical care components, such as skilled nursing care benefits, of group long-term care contracts;
5. medical benefits under group or individual automobile insurance contracts; and
6. Medicare or other governmental benefits; as permitted by law.

If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among these separate contracts.

If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan.*

Plan does not include:

1. individual or family insurance;
2. closed panel or other individual coverage (except for group-type coverage);
3. amounts of hospital indemnity insurance of $200 or less per day;
4. school accident type coverage;
5. non-medical components of group
6. Medicare supplement policies, Medicaid policies, or coverage under other governmental plans, unless permitted by law.

This Plan means the ADVANTAGE health maintenance organization plan made available to Members under this Certificate.

PRIMARY PLAN and SECONDARY PLAN

The order of benefit determination rules determines whether this *Plan* is a *primary plan or secondary plan* when compared to another *plan* covering the person. When this Plan is primary, its benefits are determined before those of any other plan and without considering any other *plan's* benefits. When this Plan is *secondary*, its benefits are determined after those of another *plan* and may be reduced because of the *primary plan's* benefits.

ORDER OF DETERMINATION BENEFIT RULES

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

(i) *Primary plan* pays or provides its benefits as if the *secondary plan* or *plans* did not exist.

(ii) A *plan* that does not contain a COB provision that is consistent with this provision is always *primary*. There is one exception: group coverage designed to supplement a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the group. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance-type coverages written in connection with a *closed panel plan* to provide out-of-network benefits.

(iii) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is *secondary* to that other *plan*.

(iv) The following rules explain which *plan* is *primary* and which plan is *secondary* in various situations. The *plan* will use the first rule that fits the Member's situation.

The *plan* that covers the person as other than a dependent (for example, as an employee, member, subscriber, or retiree) is primary and the *plan* that covers the person as a dependent is a *secondary*.

However, for a Medicare beneficiary, if Medicare is:

(i) *primary* to the *plan* covering the person as other than a Dependent; and

(ii) *secondary* to the *plan* covering the person as a Dependent; the order of benefits between the two plans is reversed so that the *plan* covering the person as an employee, member, subscriber, or retiree is *secondary* and the other *plan* is *primary*.

CHILD COVERED UNDER MORE THAN ONE PLAN

ADVANTAGE follows the Birthday Rule for Coordination of Benefits for an eligible dependent child if the: The:

(i) parents are married;

(ii)

(iii) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those timers, that *plan* is *primary*. This rule applies to *claim determination periods* or *plan* years commencing after the *plan* is given notice of the court decree.

If the parents are not married, or are separated (whether or not they have ever been married) or divorced, the order of benefits is:

(i) the *plan* of the *custodial* parent;

(ii) the *plan* of the Spouse of the *custodial parent*;

(iii) the *plan* of the non-custodial parent;

(iv) the *plan* of the Spouse of the non-custodial parent.

EMPLOYEE WITH PRIMARY AND SECONDARY COVERAGE
The *plan* that covers a person as an employee who is neither laid off nor retired is *primary*. A *plan* covering that person as a laid-off or retired employee is *secondary*. This rule also applies to dependents of such a person. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

Benefits for an individual covered as a retired worker under one *plan*, and as a dependent of an actively working Spouse under another *plan*, will be determined under the Non-Dependent or Dependent rule.

CONTINUATION OF COVERAGE
If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is *primary*, and the continuation coverage is *secondary*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

LONGER OR SHORTER LENGTH OF COVERAGE
The *plan* that covered the person as an employee, member, subscriber, or retiree longer is *primary*.
If the preceding rules do not determine the *primary plan*, the allowable expenses shall be shared equally between the *plans* meeting the definition of *plan* under this COB provision. In addition, this *Plan* will not pay more than it would have paid had it been primary.

EFFECT ON THE BENEFIT OF THIS PLAN
When *this Plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *plans* during a *claim determination period* are not more than 100% of total *allowable expenses*. The difference between the benefit payments that *this Plan* would have paid had it been the *primary plan*, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Member and used by *this Plan* to pay any *allowable expenses*, not otherwise paid during the *claim determination period.*
As each claim is submitted, *this Plan* will:

1. determine its obligation to pay or provide benefits under this Certificate;
2. determine whether a benefit reserve has been recorded for You; and
3. determine whether there are any unpaid *allowable expenses* during that *claims determination period*.

If a person is enrolled in two or more *closed panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by *one closed panel plan*, COB shall not apply between that *plan* and other *closed panel plans*.

RIGHT TO RECEIVE AND RELEASE INFORMATION
Certain facts about health care coverage and service are needed to apply these COB rules and to determine payment under a *plan*. We may get the facts We need from, or give them to, other organizations or persons for the sole purpose of applying these rules and determining the benefits payable. We will obtain Your consent for the release of personal health information upon enrollment. Each person claiming benefits under this *Plan* must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT
If another *plan* makes a benefit payment that should have been made by Us, We may pay that amount to the organization. The amount will then be treated as though it were a benefit paid under *this Plan* and We will not have to pay that amount again.
The term *benefit payment* includes providing benefits in the form of services. In such case, the amount of a *benefit payment* is the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Us is more than the amount needed to satisfy Our obligation under this COB provision, We have the right to recover the overpayment. We may recover the overpayment from:

1. one or more of the person it has paid, or for whom it has paid; or
2. from any other person or organization that may be responsible for the benefits or services provided for You.

The *amount of the payments made* includes the reasonable cash value of any benefits provided in the form of services.

ARTICLE XI – SUBROGATION/RIGHT OF REIMBURSEMENT

If Your Injury or Illness is caused by the acts or omissions of another party (including insurance carriers who are so liable), and We have provided benefits under this Certificate, We will have the right to be reimbursed if You receive any payment from the other party.
ADVANTAGE has subrogation rights against any party legally liable to pay for Your Injury or Illness.
We may assert this right independently of You.
You, or anyone acting legally on Your behalf must:

1. fully cooperate with Us in order to protect Our subrogation rights;
2. give notice of Our claim to third parties and their insurers who may be legally responsible;
3. provide Us with relevant information and sign and deliver such documents as We reasonably request; and
4. obtain Our consent before releasing any party from liability for medical expenses or services paid or provided.

If You enter into litigation or settlement negotiations regarding the obligations of other parties, You must not prejudice, in any way, Our subrogation rights.

ARTICLE XII – SEVERABILITY

In the event that any provision of this Certificate is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Certificate, which shall continue in full force and effect in accordance with its remaining terms.

ARTICLE XIII – CONTINUATION OF COVERAGE

Upon termination of the Contract by Us, a Member who is hospitalized for a medical or surgical condition on the date of termination will have continuation of coverage for inpatient services. The continuation of coverage is not required after one of the following occurs:

1) The discharge of You from the hospital;
2) Sixty (60) days pass after the Contract is terminated by Us;
3) The hospitalized Member obtains coverage from another carrier which includes coverage for inpatient services provided by Us;
4) The GROUP terminates the Contract with Us, as determined by:
   (i) The effective date specified in written communication sent by the GROUP to Us pursuant to the Contract , or
   (ii) Failure to pay a premium within the grace period permitted under the Contract.
5) Termination of a Member by Us due to:
   (i) You knowingly providing false information to Us;
   (ii) Your failure to comply with the rules stated in the Contract; or
   (iii) You fail to pay premium within the grace period permitted in the Contract.

Upon termination of a contract with an ADVANTAGE Provider. We shall be liable for payment of Covered Services rendered by such provider to You under the care of such provider at the time of termination until services being rendered to You by such provider are completed, unless We make reasonable and medically appropriate provision for assumption for such services by another ADVANTAGE Provider.

ARTICLE XIV – PAYMENT TO PROVIDERS AND CLAIMS PROVISIONS

PAYMENT TO PARTICIPATING PROVIDERS
We arrange for payment for Covered services provided by Participating Providers to be made to:

i. the Participating Provider; or
ii. a representative, agent, or provider group authorized by the Participating Provider to receive such payment.

Participating Providers may seek payment from member only for:

1. Copayments;
2. Coinsurance; and
3. Charges for non-covered services.

PAYMENT TO NON-PARTICIPATING PROVIDERS
When services are provided by a non-Participating Provider, You may need to pay the provider and then submit a claim to Us, or its designated agent. A non-participating provider may require You to pay any charges that are above the Allowed Amount.

CLAIMS FOR A DEPENDENT CHILD
If a member is the non-custodial parent of a dependent child under age 18, claims may be submitted by:

1. the non-custodial parent;
2. the custodial parent
3. a medical assistance program; or
4. the Indiana office of Medicaid policy planning

If a proper claim is timely submitted, We will provide cash reimbursement to the extent of its liability under this policy. Such reimbursement will exclude:

1. any applicable copayment or coinsurance; and
2. any amounts that may have already been paid for the services to You or the provider before the claim was received.

CLAIM PAYMENT
Claims will be paid within 45 days after We receive all information required to determine liability under the terms of this policy.
If We deny all or part Your claim, We (or Our designated agent) will provide You with a written notice that includes the reason(s) for denial.

CLAIM FILING TIME LIMIT
A claim must be submitted to us, or Our designated reprensetative, within 90days after:

1. the date the services are received; or
2. the date the member made payment

However, failure to give notice with the 90 day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within the period and that notice was given soon as was reasonably possible.

Claims for covered services rendered by providers not contracted with Us, should be sent to the mailing address indicated in the " Network Administrator" section of Your ID card. If a charge is made to You for any service that is reimbursable under the contract, written proof of such charge must be submitted to Us within forty-five days after delivery of the service and must include as itemized statement plus diagnosis. Failure to furnish such documentation within the specific period will invalidate or reduce the claim unless, for a good reason, it was not possible to submit the claim within the specific period, and such proof is produced on a timely basis as soon as possible thereafter.

We will ordinarily make payment for covered services directly to the person or institution providing the services. However, if the subscriber furnishes evidence satisfactory to Us that payment has been made by the subscriber to such person or institution for covered services, reimbursement will be made to the subscriber after deducting any payment made by Us before receipt of such evidence.

We, at Our own expense, shall have the right and opportunity to examine the member whose sickness or injury is the basis of a claim as often as it may reasonably require during the claim period.

Claims disputed by the member will be resolved by the procedures set forth in this Certificate.

ARTICLE XV – GRIEVANCE PROCEDURE

This section contains the Grievance Procedure for Members.

GRIEVANCES
We encourage You to contact the Appeals and Grievance Coordinator with any questions and/or grievances. You can file a grievance with Us up to six (6) months after You receive a notice of an adverse decision or from the date the problem occurs. Please address these issues to:

HMO Grievances

Appeals and Grievance Coordinator
ADVANTAGE Health Solutions, Inc.
9490 Priority Way, West Drive
Indianapolis, In 46240

Or, You may call Us, toll-free at 1-888-806-1029 between the hours of 8 a.m. and 5 p.m., Monday through Friday, excluding holidays. Please include the following information in correspondence, or have this information ready when telephoning:

- Subscriber's name
- Patient's name
- Subscriber's Social Security number
- Nature of the grievance

When the grievance is received, a confidential file will be opened and maintained throughout the case until resolution. The file will document the substance of the grievance and actions taken.

You should receive an acknowledgement of the grievance within three business days after We receive the grievance. All issues should be resolved within 20 business days. If this is not possible, You will receive written notice of the reason for the delay and the issue will be resolved within an additional ten business days. When the issue is resolved, You will be notified in writing within five business days. This notification will also include information about the right to appeal Our decision.

APPEALS
If the grievance is not resolved to Your satisfaction, You may appeal the decision by writing to the Appeals Committee. Please address the appeal to:

HMO Appeals
Appeals Committee
ADVANTAGE Health Solutions, Inc.
9490 Priority Way, West Drive
Indianapolis, In 46240

Or, You may call Us, toll-free, at 1-888-806-1029 between the hours of 8 a.m. and 5 p.m., Monday through Friday, excluding holidays. Please include the following information in the correspondence, or have this information ready when telephoning:

- Subscriber's name
- Patient's name
- Subscriber's Social Security number
- Date of the original grievance
- Nature of the grievance

You should receive an acknowledgement of the request for a review by the Appeals Committee within three business days. The appeal will be reviewed by the Appeals Committee. In the case of a grievance regarding medical care or treatment, the Committee will be composed of one or more individuals:

1. who have knowledge of the medical condition, procedure, or treatment at issue;
2. who are in the same licensed profession as the provider who proposed, refused, or delivered the health care procedure, treatment, or service in question; and
3. who were not involved in the matter giving rise to the grievance.

If You wish to appear before the Appeals Committee, You should make that request in the letter or telephone call requesting the appeal. You may also communicate with the Appeals Committee through other appropriate means if You are unable to appear in person.

The Appeals Committee will issue a written response to the appeal within 30 calendar days from the date the request for appeal was made. If You are dissatisfied with the resolution of the appeal, You may have the right to further remedies allowed by law.

EXTERNAL REVIEW
If the grievance is not resolved to Your satisfaction through the appeals portion of the grievance procedure, You may have the right to an external review.
WHEN EXTERNAL REVIEW APPLIES

External review applies to grievances concerning the following types of determinations made by Us, or Our designee, regarding a service proposed by a treating Physician:

1. adverse utilization review determinations;
2. adverse determinations of Medical Necessity; and
3. determinations that a proposed service is experimental or Investigational.

REQUESTING AN EXTERNAL REVIEW

After receiving the Appeals Committee's response to the appeal, You, or Your representative, may file a written request for external review. You must make the request within 45 days after receiving the notice.

You may be assisted by any other individual in the external review. This includes Physicians, attorneys, friends, or family members.

You may submit additional information throughout the external review process.

You may pay $25 for an external review.

You are entitled to one external review for each grievance that is not resolved to Your satisfaction by the Appeals Committee.

EXPEDITED EXTERNAL REVIEW

If the grievance is related to an Illness, disease, condition, disability, or Injury that would jeopardize Your life, health, or ability to reach and maintain maximum function, the external review will be handled on an expedited basis.

INDEPENDENT REVIEW ORGANIZATION

When You file a request for external review, We will select an independent review organization (IRO), on a rotating basis, from a list of IROs that have been certified by the Department of Insurance.

The IRO will then assign a medical review professional who is board-certified in the applicable specialty to perform the external review.

Neither the IRO nor the medical review professional can have a conflict of interest with any of the parties involved; however, the medical review professional may have:

1. an affiliation with Us to provide health care services to enrollees; or
2. staff privileges at a health facility where the service in question would be provided;
3. as long as this is disclosed to You and us before the external review begins and no one objects.

RECONSIDERATION BY ADVANTAGE

If You submit any additional information which is relevant to Our decision, the external review process will stopped. We will then have the opportunity to reconsider Our decision. We will notify You of Our reconsideration decision:

1. within 15 days for a standard review
2. within 72 hours for an expedited review

If You are not satisfied with Our reconsideration decision, You may request that the external review be resumed.

COOPERATION IS REQUIRED

Both You and We are expected to fully cooperate with the external reviewer by promptly providing necessary documentation and/or signing any necessary releases. You will not be subject to any retaliation for asking for, or proceeding with, an external review.

TIME LIMITS FOR RESOLUTION

For a standard external review, the IRO must: make a determination with 15 business days; and then notify You and Us of its determination within 72.

For an expedited external review, the IRO must: make a determination with 72 hours; and then notify You and Us of its determination within 24 hours.

The IRO will make its determination based on standards of decision-making that are based on objective clinical evidence and the terms of this Certificate. This determination is binding on Us; however, You may have additional remedies under the law.

NOTE: If You are not satisfied with the IRO's determination, You have the right to request arbitration, as explained in the section titled Arbitration. You must exercise this right within 90 days after receiving notice of the IRO's determination.

CONFIDENTIALITY

Documents and other information created or received by the IRO or medical review professional in connection with an external review are not public records and must be treated in accordance with confidentiality requirements of state and federal law. However, the work product of an IRO may be admissible in judicial or administrative proceedings.

DESIGNATING A REPRESENTATIVE

You may designate a representative to file a grievance for You and to represent You in the resolution and/or appeal of any grievance. You may need to sign a release in order to allow Us to discuss the situation with Your representative.

RESOLUTION TIME FRAMES
We will attempt to resolve grievance and appeals within the time frames specified above. We will always consider the clinical urgency of any grievance relating to medical care and treatment. The Vice President, Medical Affairs or the Medical Director will review all grievances relating to medical care and treatment and determine whether they are routine, urgent, or emergent. These grievances will be resolved in the following time frames:

Routine	within 20 working days
Urgent	within two working days
Emergent	within one working day

Your satisfaction is very important to us. We have set up the above Grievance Procedure to help ensure that any problem with the Contract is addressed in a fair and timely manner. We fully expect to provide a fair settlement for every valid grievance in a timely manner. However, should You feel that You are not being treated fairly, You may write or call the Indiana Department of Insurance with a grievance.

Indiana Department of Insurance
311 West Washington Street, suite 300
Indianapolis, IN 46204-2787
Consumer Hotline: 1 (800) 622-4461 or
Indianapolis area: (317) 232-2395

ARTICLE XVI – INFORMATION AND ADMINISTRATIVE OFFICE

The telephone numbers located below, are available to assist You with requests for information or complaints regarding the health care services under the Contract.

Inquiries and Eligibility: (317) 573-6228 or (800) 553-8933
Hearing Impaired: (800) 743-3333

MAIN OFFICE
The main office of ADVANTAGE is located at:
9490 Priority Way, West Drive, Indianapolis, Indiana 46240

In addition to arranging comprehensive medical benefits, We strive to provide You with information regarding how to use the benefits and obtain Covered Services. We have specially trained, Member Service Representatives to assist with questions about:

- Covered Services
- Making address or phone number changes
- Primary Care Physician changes
- Enrollment or Disenrollment
- Appeal or Grievance rights
- Medical care when you are traveling
- The care you are receiving
- Any other questions or concerns regarding the plan

ARTICLE XVII – ASSIGNMENT OF BENEFITS OR PAYMENTS

You are not permitted to assign benefits or payments for services covered under this Certificate.

ARTICLE XVIII – CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

The GROUP contract will include a provision that prohibits the GROUP from utilizing released information for any decisions affecting employee; contract will also state the GROUP will take all precautions to protect information released by Us.

If GROUP conducts an audit of Us that involves personal health information under Our or delegates' control, no identifiable information will be accessed by auditor without Your signed special consent forms.

In accepting Coverage under this Certificate, you authorize Us to have access to any health records and medical information held by any Provider who delivers health services to You. You also authorized Us, Our representatives, and participating

Providers to use Your general medical record, when necessary, for referrals, Case Management, claims processing, underwriting (for the purpose of reinstatement or adding a Dependent), and evaluation of potential or actual claims against Us.

ADVANTAGE Health Solutions ensures patient information is handled with a high level of confidentiality. You are presented with the opportunity to provide informed consent for the use of medical records and information.

Informed consent must be obtained directly from You, or in the case of those individuals unable to provide informed consent by reason of age or mental disability, We will obtain consent from the individual authorized to provide consent under state and federal laws.

- Routine Consent – Upon enrollment, members are provided with a routine notification and consent form (sometimes included in the enrollment application). Routine consent permits Us to utilize Your personal medical information for future, known or routine needs in the course of arranging for health care. Such needs for information may include treatment; coordination of care; quality assessment and measurement; the health plan's accreditation; and, decisions about the payment of services. In the use of personal medical information for these purposes, We may transmit information to people or organizations outside of ADVANTAGE Health Solutions who contract with us for the purpose of arranging for Your health care and benefits.

- Special Consent – There may be times when We or Our contractors may have to obtain special consent to obtain Your personal medical information for special situations. Situations that would require special consent may include: a request for information from another insurance carrier (workers' compensation, auto insurance, etc.); a court order or subpoena; any release of information that could result in You being contacted by another organization for marketing purposes; and data used for research studies. In these situations, You will be contacted to provide consent to release specific information. Our request will detail the purpose of the consent, a description of the information to be released, the conditions under which You are providing consent, and a statement that the consent may be revoked by You at anytime. We maintain policies to ensure that personal health information is protected and is not accessible by individual that do not have a need to access the information. Whenever identifiable information is unnecessary, We remove identifiable information prior to the release of personal health information. At anytime, You have the opportunity to consent to r deny the release of identifiable medical or other information, except when such release is required by law. You also have the right to access Your own medical records by contacting the rendering provider and You have the right to amend the medical records that are within Our control. If You are unable to provide special consent due to age, mental incompentency, or death, We will look to the appropriate authorized individual (guardian, power of attorney, executor, etc.) to provide special consent.

  We are committed to protecting the privacy and confidentiality of personal health information. Information will not be used or released for purposes other than provided under the routine consent given at enrollment, unless You have provided special consent to use or release information in other circumstances. We will not release personal identifiable information to an employer.

  You may revoke the consent to release personal health information at any time by writing to ADVANTAGE health Solutions, Member Services, 9490 Priority Way, West Drive, Indianapolis, Indiana 46240. You may also write to Us to request access to Your medical records which are under the control of Us and Our contracted associates, and if You wish, request to amend those records. Please contact an ADVANTAGE Health Solutions Member Services Representative for more information.

  For more information about Our policies and procedures protecting the confidentiality of You information and records, contact ADVANTAGE's Member Services Department.

ARTICLE XIX – RELATIONSHIP AMONG PARTIES AFFECTED BY AGREEMENT

The relationship between Us and Our contracting Hospitals is that of independent contractors. Hospitals are not agents or employees of Ours nor are We, or any employee of Ours, an employee or agent of Hospitals. Hospitals are responsible for maintaining the Hospital-patient relationship with You are solely responsible to You for all Hospital services.

Contracting Providers may receive a financial incentive from us to appropriately manage the provision and cost of services rendered to You.

Neither the GROUP, nor any Member, is an agent or representative of Ours. Neither the GROUP nor any Member shall be liable for any acts or omissions of Ours, Our agents or employees, or of any Health Professional, or Hospital, or any other person or organization with which We, Our agents or employee, has contracted for the performance of services under this Certificate.

Certain Members may, for reasons personal to themselves, refuse to accept procedures or courses of treatment recommended by an ADVANTAGEparticipating provider. Participating Provider shall use their best efforts to render all necessary and appropriate professional services in a manner compatible with the Member's wishes, insofar as this can be done consistently with the the requirements of proper medical practice. If a Member refuses to follow a recommendation treatment or procedure, and a participating provider believes that no acceptable alternatives exists, such Member shall be so advised. The Member will have the right to consultation (second opinion) from an appropriate ADVANTAGE participating provider. If there is agreement among the participating provider and consulting provider as to the course of treatment, and if upon being so advised, the Member still refuses to follow the recommended provide or pay for treatment for such condition until such time that the Member agrees to follow recommended treatment or procedure.

ARTICLE XX- NOTICE OF PRIVACY PRACTICES

ADVANTAGE is required by applicable federal and state laws to maintain the privacy of the member's medical information. We are also required to give each member this notice about our privacy practices, our legal duties, and the members' rights concerning their medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2003, and will remain in effect until replaced.

ADVANTAGE reserves the right to change privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. ADVANTAGE reserves the right to make changes in its privacy practices and the new terms of its notice effective for all medical information maintained, including medical information ADVANTAGE created or received before the changes were made. ADVANTAGE will advise Subscribers of any such change.

Members may request a copy of the Notice of Privacy Practices at any time, or they may immediately obtain a copy of the Notice of Privacy Practices by visiting the ADVANTAGE web site at www.advantageplan.com.

USES AND DISCLOSURES OF MEDICAL INFORMATION

ADVANTAGE will use and disclose medical information about members for treatment, payment and health care operations under the following circumstances:

- ***Treatment:*** ADVANTAGE may disclose medical information to a doctor or hospital , upon request, to provide treatment to members.

- ***Payment:*** ADVANTAGE may use or disclose the medical information to pay claims for services provided to the member by doctors or hospitals which may or may not be covered by the health plan.

- ***Health Care Operations***: ADVANTAGE may use or disclose medical information to determine its premiums for health plan coverage, conduct quality assessments and improvement activities, to engage in care coordination or case management, to manage its business, and the like.

- ***To Member and on Member Authorization***: ADVANTAGE must disclose the Member's medical information to them, as described in the Individual Rights section of this notice, below. The member may give written authorization to use his/her medical information or to disclose it to anyone for any purpose. If Member gives ADVANTAGE an authorization, he/she may revoke it in writing at any time. The revocation will not affect any use or disclosure permitted by the authorization while it was in effect. Without this authorization, ADVANTAGE may not use or disclose the medical information for any reason except those described in this notice.

    - ***To Family and Friends***: If Member agrees, if Member is unavailable to agree, when the situation, such as medical emergency or disaster relief, indicates that disclosure would be the Member's best interest, ADVANTAGE may disclose the Member's medical information to a family member, friend or other person to the extent necessary to help with the Member's health care or with payment for health care services.

- ***Underwriting***: ADVANTAGE may receive medical information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. ADVANTAGE will not use or further disclose this medical information for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with ADVANTAGE. In that case, the use and disclosure of medical information will only be as described in this notice.

- ***Marketing***: ADVANTAGE may use medical information to contact the Member with information about health-related benefits and services, including but not limited to: ADVANTAGE's disease management programs and quality improvement activities that may be of interest to the Member. ADVANTAGE may disclose medical information to a business associate to assist in these activities. Unless the information is provided to the Member by a general newsletter, in person, or is for products or services of nominal value, Member may opt-out of receiving further such information be advising ADVANTAGE using the contact information listed at the end of this notice.

- ***Research: Death: Organ Donation***: ADVANTAGE may use or disclose medical information for research purposes in limited circumstances. ADVANTAGE may disclose the medical information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

- ***Public Health and Safety***: ADVANTAGE may disclose medical information to the extent necessary to avert a serious and imminent threat to Member's health or safety or the health or safety of others. ADVANTAGE may disclose medical information to a government agency authorized to oversee the health care system or government programs or its contractors, and public health authorities for public health purposes. ADVANTAGE may disclose medical information to appropriate authorities if it is reasonably believed that Member is a possible victim of abuse, neglect, domestic violence or other crimes.

- ***Required by Law:*** ADVANTAGE may use or disclose medical information when required to do so by law. For example, ADVANTAGE must disclose medical information to the U.S. Department of Health and Human Services upon request for purposes of determining whether ADVANTAGE is in compliance with federal privacy law. ADVANTAGE may disclose medical information when authorized by workers' compensation or similar laws.

- ***Process and Proceedings***: ADVANTAGE may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, ADVANTAGE may disclose medical information to law enforcement officials.

- ***Law Enforcement***: ADVANTAGE may disclose limited information to a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. ADVANTAGE may disclose the medical information of any inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. ADVANTAGE may disclose medical information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

- ***Military and National Security***: ADVANTAGE may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. ADVANTAGE may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other national security activities.

DISCLOSURE OF INDIVIDUAL RIGHTS
The following Notice of Privacy Rules information will be provided to Subscribers in accordance with ADANTAGE's Notice of Privacy Policy and Procedures

- ***Access***: You have the right to inspect or obtain copies of your medical information, with limited exceptions. You may request that ADVANTAGE provide copies in a format other than photocopies (i.e. electronic). We will use the format you request unless we cannot practicably do so.

  You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, you may incur a minimal charge for the copies for each page and per hour for staff time to locate and copy your medical information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your medical information in that format. If you prefer, we will prepare a summary or an explanation of your medical information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

- ***Disclosure Accounting***: You have the right to receive a list of instances in which ADVANTAGE or our business associates disclosed your medical information obtained or created since April 14, 2003 for purposes other than treatment, payment or health care operations and certain other. We will provide you with the date(s) on which we made the disclosure, the name(s) of the person or entity(ies) to whom we disclosed your medical information, a description of the medical information disclosed, and certain other information. If you request this list more than once in 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

- ***Restriction Request***: You have the right to request that ADVANTAGE place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement ADVANTAGE may make to a request for

additional restrictions must be in writing and signed by a person authorized to make such an agreement on your behalf. ADVANTAGE will not be bound unless our agreement is so memorialized in writing.

- ***Confidential Communication***: You have the right to request that ADVANTAGE communicate with you in confidence about your medical information by alternative means or to an alternative location. You must inform us that confidential communication by alternative means or to an alternative location is required to avoid endangering you. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative location you want. ADVANTAGE must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan.

- ***Amendment***: You have the right to request that ADVANTAGE amend your medical information. Your request must be in writing, and it must explain why the information should be amended. ADVANTAGE may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

- ***Electronic Notice***: If you receive this notice on our web site (www.advantageplan.com) or by electronic e-mail, you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

QUESTIONS AND COMPLIANTS

If you are concerned that we may have:

- Violated your privacy rights;
- You disagree with a decision we made about access to your medical information;
- In response to a request you made to amend or restrict the use or disclosure of your medical information; and/or
- In response to a request you made to have us communicate with you in confidence by an alternative means or at an alternative location

You may complain to ADVANTAGE using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

ADVANTAGE supports your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services. If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

CONTACT INFORMATION

CONTACT OFFICE:	**ADVANTAGE Health Solutions, Inc.** 9490 Priority Way West Drive Indianapolis, IN 46240	
ATTENTION:	Member Services Department Supervisor	
TELEPHONE:	Toll-Free:	1-800-553-8933
	TDD (hearing impaired):	1-800-743-3333
HOURS OF OPERATION:	7:30 a.m. – 5:30 p.m. (Monday-Friday)	